

**Investigation into the circumstances surrounding the death  
of a man in November 2009  
at HMYOI Portland**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**August 2011**

This is the report of an investigation into the death in November 2009 of a man, a prisoner at HMYOI Portland. At about 6.30am that morning, he was found hanging in his cell. Paramedics arrived quickly but he was pronounced dead. It was just six weeks after his 18<sup>th</sup> birthday. He had been in custody since 15 October 2009, but had only been at Portland for four days.

I extend to his family and friends my sincere sympathy and condolences for their tragic and untimely loss.

The investigation was conducted by my colleague. It has been a complex and protracted investigation as many issues have been examined. For this reason, he was assisted at various times throughout the investigation by other colleagues. As important as it has been to ensure that the report is accurate and thorough, I recognise that the delay issuing may have added to the anxieties felt by the family. I offer them my apologies for this.

As part of the investigation, I commissioned a clinical review of the management of his health needs while he was in custody. This was conducted by a clinical reviewer on behalf of the local Primary Care Trust. I am most grateful to him for his contribution to the investigation.

I would also like to thank the Governors at Portland and HMYOI Feltham, and their staff, for their co-operation and assistance. I owe special thanks to the liaison officers. I also extend my thanks to the staff at the Youth Offending Service, some of whom had known him for a number of years and had built up a good relationship with him.

He was a troubled 18 year old who, just over a week before he was found hanging, had been sentenced to five years imprisonment. When sentenced, there was no indication that he might harm himself and he had not harmed himself when he had been in custody before. His transfer to Portland, a prison some distance from his family was, I judge, a significant factor.

My report includes two recommendations which primarily relate to Feltham. The first relates to ensuring that follow-up action is taken when risks are identified on cell sharing risk assessments. The second refers to the importance of completing allocation and transfer documentation for young prisoners, ensuring that any concerns relating to their transfer are documented. I also make further reference to HM Chief Inspector of Prisons report which made a number of recommendations relating to the general state of the accommodation in Portland. I hope that my recommendations will prevent a similar tragedy occurring.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Thea Walton**  
**Acting Prisons and Probation Ombudsman**

**August 2011**

## **CONTENTS**

Summary

The investigation process

Background

HMYOI Portland  
HMYOI Feltham

Key findings

Issues

Conclusions

## **SUMMARY**

The man was just 18 years old when he was found hanging in his single cell at HMYOI Portland in November 2009. At the time of his death, no concerns had been raised about his risk of self-harm or suicide.

He was serving a five year sentence and had been in custody since 15 October 2009. He was initially remanded to HMYOI Feltham, and from there went to HMYOI Reading. He was transferred back to Feltham and finally to Portland on 18 November, four days before his death.

Prior to 15 October, he had spent other periods in custody at Feltham. While his behaviour was good at times, he was also involved in fights and altercations with other prisoners. He also struggled with education, although his family and staff at the Young Offender Service made good efforts to support him.

His life changed significantly in a short period of time. Having been convicted of the offence, he went to court on 13 November. He was given a five year prison sentence, which was less than he and his solicitor expected. This was followed by a transfer to a prison some distance from his home and family. My investigation has found no reason to believe that prison staff, or anyone else, suspected that he would harm himself.

At around 8.30pm on Saturday 21 November, he was checked and all seemed well. At the next check, the following morning at just after 6.30am, he was found hanging. Staff went into the cell and cut the ligature. No attempt was made to resuscitate him as rigor mortis was present. Ambulance paramedics arrived soon after and he was pronounced dead.

A note was found in his cell after he died. He sent his love to his girlfriend and indicated that he could not serve his prison sentence.

The clinical reviewer has found that his clinical care and treatment was comparable to that which he could have expected in the community. My report includes two recommendations which primarily relate to Feltham. The first is aimed at ensuring follow-up action is taken when risks are identified when a cell sharing risk assessment is completed. The second refers to the importance of fully completing allocation and transfer documentation for young prisoners, ensuring that any concerns relating to their transfer are documented.

## THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by one of the Ombudsman's investigators on 25 November 2009, when he met the Governor of Portland and some of his staff. Notices of the investigation and terms of reference had already been sent to invite anyone with any information to contact the investigator. Notices were also sent to HMYOIs Feltham and Reading as he had spent previous periods in custody there.
2. The investigator also met the Head of Healthcare, representatives of the Prison Officers' Association and a representative of the Independent Monitoring Board. He visited all parts of the prison including the wing where the man lived, and met the prison's liaison officers.
3. The man's prison records, including his medical record, were made available to the investigator during his initial visit to the prison. Additional documents were made available when he returned to conduct interviews. Telephone transcript data was also provided.
4. As he had only been at Portland for four days, the investigator also reviewed his prison records from HMYOI Feltham, where he transferred from. This was followed by a number of interviews with staff there. Because of the complexities of investigating the death of a young person in custody, the investigator was assisted at various times in the investigation by other colleagues from this office.
5. The investigation team also met with Youth Offender Service (YOS) and would like to thank the Head of Service and his staff for their assistance. The YOS shared their records and knowledge of him throughout the investigation and I do not underestimate the valued work they did with him in the two years they had contact with him.
6. A clinical review was commissioned from the local Primary Care Trust to examine his medical care. I am grateful to the clinical reviewer for his review. He reviewed his records from his community doctor and the prison healthcare, and also transcripts of interviews undertaken by the investigator.
7. One of the Ombudsman's Family Liaison Officers contacted the man's mother to inform her of the investigation and give her the opportunity to raise any questions or concerns about the care her son received. The investigator and Family Liaison Officer met her and her solicitor during the course of the investigation. The family raised a number of concerns which I have listed below. I hope that my report provides them with a better understanding of the events leading to his death.

### At HMYOI Reading

- Was he subject to 30 minute checks while he was at Reading?

- Did he share a cell at Reading with someone who was known to be from a rival gang?
- Was he subject to aggressive cell searches at Reading and Feltham?
- Is there any evidence that he was targeted or bullied by rival gang members during his time in custody?
- Is there any evidence that he may have been bullied during his transfer to Portland?

#### At HMYOI Portland

- Why was Portland chosen above other YOIs closer to his home and family?
  - Did he receive a mental health assessment following sentencing, given this was a change in his circumstances?
  - Why did his Cell Sharing Risk Assessment appear to fluctuate between low and medium risk?
  - The family was concerned by the state of repair of his cell. The toilet was black with limescale, the furniture broken and the bedding dirty. They questioned the effect this could have on someone's state of mind, given their likely anxiety having arrived at a new prison.
  - The family were told that he was checked when the power was switched off at 2.30am on the morning that he died and he was fine. This is, however, contrary to the records which state that no checks were made during the night.
8. The man's mother and her legal representative received a copy of my draft report as part of the consultation process. Written representations were provided on behalf of his mother in response to the findings of the investigation. A number of issues were raised including the prison's failure to identify him as a high risk prisoner, the alleged bullying of him, the handling of his transfer to Portland, the timing of the induction programme at Portland and the subsequent time he spent confined to his cell and the adequacy of the response when he was found. I am grateful to the family for the time they have taken to consider the report and for the feedback they have felt able to share. The investigator has considered the issues raised and has, where appropriate, amended the report to reflect their comments. It was felt, however, that some of the issues raised would be more appropriately addressed outside of this report. The investigator has sought to address these in separate correspondence to the man's mother and legal representative.

## **BACKGROUND**

### **HMYOI Portland**

9. Portland opened in 1848 and held convicted adults until 1921, when it was converted into a borstal (a type of youth prison intended to reform seriously delinquent young people). It has been a Young Offender Institution since 1988, and today holds young men aged between 18 and 21. Portland has an operational capacity of 624.
10. The prison's accommodation is in nine house blocks. Benbow, Raleigh, Drake, Nelson, Grenville, Rodney, Hardy, Collingwood, and Beaufort. Rodney and Hardy have electronic night sanitation (the cell door unlocks for a limited time to allow the prisoner to go to the toilet), while the others have in-cell sanitation. Hardy was closed in 2009 and Rodney was closed in early 2010 for refurbishment. Grenville House is an Induction Unit, Beaufort is a Skills Development Unit, and Raleigh is the Resettlement Wing and Collingwood a 'Super enhanced' wing. There is also a Care and Control Unit.
11. Healthcare services are provided from 7.45am to 8.00pm on weekdays and from 8.00am to 5.30pm at weekends and so no healthcare staff were present.

### **HM Chief Inspector of Prison's report**

12. The most recent report on Portland by HM Chief Inspector of Prisons followed a full announced inspection in July 2009, issued approximately two months before the man died. The Chief Inspector noted:

“...It is in a remote location far away from most of its young offenders' homes, mostly with old and forbidding buildings, some not fit for use. Until fairly recently, staff attitudes and approach were equally negative and outdated. This inspection, however, found a prison which had changed both its outlook and its outcomes: with a focus on trying to provide a positive and rehabilitative experience for the young men placed there, in spite of the physical difficulties of the site.

“We have inspected other prisons recently, in unpromising locations in rural areas far from prisoners' homes, where we have found managers and staff sunk into a condition of learned helplessness: expecting and providing little. This was far from the case at Portland. Managers recognised the problems of location and environment, but were nevertheless determined to create a space in which young men could have new and different opportunities. This had required a great deal of effort, both with external partners and, equally importantly, from the whole staff group.”

“Cells on the [induction unit] were appropriately equipped with basic toiletries, writing materials and information leaflets, but not all had been cleaned satisfactorily and some had graffiti.

“Many cells had noticeable amounts of graffiti, some obscene, on doors, walls and furniture. Many walls were covered in toothpaste residue used to display posters and pictures. We also saw some broken furniture in cells. Some toilets and toilet screens were badly stained.”

13. Under the heading of “Safety”, the HMCIP report included the following in its observations:

“Reception, first night and induction procedures were generally good though prisoners were unoccupied for lengthy periods during induction. Arrangements to prevent violence and self-harm were reasonable, but the number of violent incidents and the use of force were significant. “However, there was little evidence that most prisoners felt unsafe or intimidated, and the prison's response to the threat of gang activity was proportionate.

“An assessment of risk was incorporated into the induction passport document completed for all new arrivals, and staff were alert and responsive to potential risk factors. There were no designated first night cells on the first night and induction unit, but staff were familiar with the arrangements to identify new arrivals. Cells were prepared appropriately, although not all were clean.

“Prisoners were reasonably positive about the content of the two-week induction programme, although they complained about the time they spent in cell between sessions. This was compounded by the wait to start the programme, which was not run on a rolling basis.”

### **Independent Monitoring Board (IMB) report**

14. IMB members are lay people appointed to each prison by the Secretary of State for Justice to monitor the treatment of prisoners. They are not members of the Prison Service, nor are they part of the prison's management team. They are required to report annually to the Secretary of State, highlighting good practice and any areas of concern. The IMB annual report for HMP Portland for the period 2009/2010, stated:

“Our role is to monitor the just and humane treatment of prisoners and the range and adequacy of the programmes preparing them for release. The Board reports on how well the prison meets the standards and requirements placed on it and what impact these have on those in its custody. Portland has performed extremely well against these criteria and the rate of beneficial change appears to be increasing.”

### **Induction**

15. At Portland, after their reception checks are completed, all new prisoners are located to Grenville, the induction wing. All cells are single occupancy. Prisoners are asked whether they have any immediate concerns, such as disability, and about their general well being. The induction includes a further

assessment, medical screening, and input from the education and offender management units. Prisoners are given a new reception pack, and telephone pin numbers and visiting arrangements are explained. Prisoners remain on the induction wing for around two weeks before being moved onto a residential wing.

16. The induction programme starts on a Monday and lasts for four days. Prisoners are interviewed and attend workshops delivered by various representatives from the different agencies that work within the prison, such as Samaritans, Safer Custody and the education department.

### **Critical Debrief**

17. A critical debrief takes place after a serious incident. It gives the staff the opportunity to understand the incident in greater detail, review their feelings and normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment and using the briefing as a learning event to try and prevent repeat incidents.

### **Cut down tools**

18. Cut down tools, also known as ligature or fish knives (because of their shape), are designed for safely cutting ligatures and are carried by all officers and healthcare staff in contact with prisoners.

### **Incentive and Earned Privilege Scheme (IEP)**

19. There are three levels of prison regime under the Incentives and Earned Privileges (IEP) scheme, that is basic, standard and enhanced. The higher the regime, the more privileges a prisoner is allowed. Basic regime can be imposed for a number of reasons including bad behaviour and failure to comply with sentence planning.

### **Listeners and Greeters**

20. Listeners are prisoners trained by the Samaritans to provide a confidential service for other prisoners. They do not offer counselling but offer support, particularly for prisoners at risk of self harm.
21. Greeters in Portland are prisoners who volunteer to work in the Induction wing, welcoming new prisoners and explaining the processes they will encounter in the early days of custody.

### **Reception**

22. A Cell Sharing Risk Assessment (CSRA) is opened by reception officer who complete the basic details. The form is handed to the First Night Centre staff where a confidential interview is conducted. The document is then passed to healthcare staff. The CSRA is intended to provide consistent and continuing

risk assessment regarding sharing cells. While primarily concerning cell sharing, it also includes other occasions when space may be shared, for example to accommodate a Listener.

23. Reception staff do not routinely have access to a prisoner's past records and so the prisoner is the main source of information. If a prisoner has transferred in, his past record would arrive with him. All prisoners will also have a Person Escort Record (PER, a document used when escorting a prisoner between prisons, court and police stations) which includes risk pertinent information such as risk to others and self.
24. The initial healthcare screen concentrates on the prisoner's immediate well-being, their mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.

### **Roll check**

25. The roll check is the physical count of the number of prisoners on each wing with a prison. Roll checks occur on a number of specified occasions during the day and night, and staff must sign that the roll is correct.
26. At the weekends prisoners are unlocked for breakfast at approximately 8.40am, lunch at about 11.30am and dinner at 4.30pm. Their cells are also normally unlocked for two periods of association. The first commencing at 10.30am for about an hour, and the afternoon/evening association commencing around 2.00pm for two hours. Between unlock at 8.40am and around 4.45pm, prisoners can attend church, the gym, visits and healthcare. The evening roll check is carried out at about 5.20pm when prisoners are locked in their cells for the night.

### **Sealed key pouch**

27. Operational Support Grades are generally on duty at night. OSGs do not have keys to cells but carry a sealed pouch which contains a cell key which should only be used in emergencies. During the night state, the whole house block is also locked and the OSGs are locked within it. The house block doors can only be opened by the night orderly officer, who is in charge of the prison, and who will visit (and contact via radio) each house block throughout the night to check that everything is satisfactory. OSGs can communicate with others outside of their house block by radio or using the telephone in the office.

### **Suicide and self harm monitoring**

28. The Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, identify prisoners' individual needs, and provide individualised care and support before, during and after a period of crisis.

## **HMYOI Feltham**

29. The original Feltham was built in 1854 as an Industrial School and was taken over in 1910 by the Prison Commissioners as their second borstal institution. The existing building opened as a Remand Centre in March 1988. The current HM Prison and Young Offender Institution Feltham was formed by the amalgamation of Ashford Remand Centre and Feltham Borstal in 1990/91. As at 2nd February 2009, Feltham's operational capacity was 762 prisoners.
30. Feltham holds young people from the age of 15 to 18. It also holds young adults from the age of 18 to 21 placed in custody by the courts.
31. The grounds cover a large area, which is divided into two distinct and separate residential sites. Young people under the age of 18 are accommodated in Feltham A and young adult prisoners between 18 and 21 years old in Feltham B. There are currently eight units for young people; one of which is Bittern, the first night and induction unit. Each unit holds 30 young people.
32. Almost all the rooms are for single occupation. All rooms have integral sanitation and TV. All areas operate the IEP scheme (Incentives and Earned Privileges Scheme). There is an anti-bullying policy in place.
33. Feltham A and B run individual regimes. There are some services that are shared by Feltham A and B, principally the Healthcare Centre, the Chapel and the gym, and accessed from a shared corridor.
34. There are personal identification number (PIN) phones on each unit and every young adult and young person is given his own PIN with an automatic £2 credit when they arrive at Feltham. A similar PIN telephone system operates across the prison estate.

## **Youth Offending Service (YOS)**

35. The Youth Offending Service (YOS) aims to prevent young people from offending, and to reduce re-offending by young people already known to the police and the courts. The team is made up of staff employed by the council to provide youth justice services, and specialists from partner agencies such as the police, education, youth and Connexions services, health and probation services and voluntary organisations.

## **Asset**

36. Asset is a structured assessment tool to be used by youth offending teams in England and Wales with all young offenders who come into contact with the criminal justice system. It aims to look at the young person's offences and identify factors or circumstances, ranging from lack of educational attainment to mental health problems, which may have contributed to such behaviour. The information gathered from Asset is used to inform court reports so that appropriate intervention programmes can be drawn up. It also highlights any particular needs or difficulties the young person has, so that these can be

addressed. Asset will also help to measure changes in needs and risk of re-offending over time.

### **Supervision Orders**

37. A Supervision Order is a court order made to help a young person to avoid any further offending. It can last up to three years. This order is supervised by a member of the Youth Offending Service who is there to advise, assist and encourage the young person, and will help to prevent them re-offending.

## KEY EVENTS

38. On 6 July 2007, then aged 15, the man returned to London having lived in a specialist care home in Birmingham for two and a half years. He and his brother originally came to the attention of Social Services because they were unable to be cared for by their parents. His placement in the care home was largely due to his learning needs and social conduct disorder. (Conduct disorder is a group of behavioural and emotional problems in children and adolescents who have difficulty following rules and behaving in a socially acceptable way.) He was considered by the courts to be a persistent young offender because of the number of offences he had committed since 2002, when he was ten.
39. He was released into the care of his mother, although technically he was under a full care order from Social Services until he was 18. During the first three months after he returned to London, he appeared to settle well with no reported incidents. However, he began to spend more time with some of his old criminal peers. By October 2007 his offending had resumed and he was arrested for the offence of assault.
40. In January 2009, he was given a 12 month supervision order by the courts for a previous offence. He was placed under the supervision of the Youth Offending Service (YOS) for a year. He was required to attend their office regularly for support and to address his offending behaviour. He had been subject to a number of other supervision court orders over the years. On the whole, he complied with their requirements although his attendance was sometimes erratic.
41. A YOS Officer was assigned to him in January 2008 and she had regular contact with him. She was interviewed by the investigation team. She said that he was a very likeable young man but he was confused. He did not know how to articulate his emotions or feelings and it took him quite a long time to build up any form of trust with her. He was isolated, had no friends and no social network where he lived.
42. Due to his haphazard early life, he had little education and severe learning needs. Being under a full care order, he was expected to engage with the Sure Start Foundation project. This involved regular meetings with their social worker who had been assigned to act as a mentor to him. The mentor was asked to help him adjust to being back in London, at home and with his family.
43. At interview with the investigator, the mentor said that he initially met him about three times a week. They did creative work such as gardening and he also helped to ensure that he went to his YOS appointments by taking him in his car. This seems to have helped him, who the mentor described as someone who did not engage well with adults. He said that working with he was “challenging but enjoyable because he was a lovely lad”. The mentor’s work was assisted by the man’s mother who wanted to ensure that her son complied with his supervision order.

44. During the early contact between the YOS Officer, the mentor and the man, when he was still of school age, he refused to go to school. He could not read or write and wanted to take up full time employment. The YOS Officer tried to encourage him to become involved in a number of YOS projects and managed to agree a reduced educational timetable for him. This focused on core subjects such as Maths, English and Information Technology. She said that, although difficult, both she and his mentor formed a good relationship with him.
45. She told the investigation team that he often displayed a level of immaturity which resulted in impulsive behaviour which the YOS tried to address with him. A lot of his behaviour was alcohol induced which made him more violent and aggressive. Despite this, she said that he never gave her any indication of ever wanting to harm himself.
46. The mentor said that after he returned to live with his mother and settled in his new surroundings, he began to try to re-establish himself amongst some of his old peers. He liked to be "top dog" which attracted the pressures of managing his peer group. He told my investigator that he soon learnt that, although he was a 16 or 17 year old teenager, he often behaved like a 14 year old.
47. The YOS Officer's contacts with him were documented in the YOS contact electronic log. She and other members of the YOS met and communicated with him. His parents were included as far as possible to help support him, especially to ensure that he did not commit any more offences. She arranged a number of activities and workshops to deal with conflict resolution skills, behaviour and educational and social needs. As he had declared that he spent about £20 per day on cannabis, sessions with local drug misuse adviser service were also arranged.
48. In October, having committed a number of offences ranging from disorderly behaviour to harassment, he received a 12 month Community Punishment Order (CPO) with a curfew. He was also instructed to wear a tag. His YOS Officer encouraged him to adhere to his curfew and accept the support but she encountered difficulties as he would often not engage with the YOS or its services.
49. In November, he accepted that he needed help with reading and writing and started to attend one hour per week education support at the YOS. However this was short lived, as in a meeting on 18 November, he was withdrawn, negative and said that he did not care about continuing.
50. The mentor's contact with him was initially quite structured and they agreed specific days when they would meet. They often went to the gym together which he enjoyed. As time went on, their meetings became more flexible to accommodate his attendance at the education classes. Returning to the classroom was difficult for him and he was involved in a few fights. The mentor and the YOS Officer liaised to discuss ways of supporting and motivating him to continue with his education and avoid offending. The mentor said the difficulties were that he "never looked beyond where he was at, it's where he was at, not where he could get to".

51. On 1 December, he was arrested and remanded overnight to go to the Youth Court the following morning. He was charged with nine offences including breach of bail conditions, common assault and theft. He was bailed by the court to appear at a later date.
52. The YOS Officer continued to meet regularly with him. In their meeting on 11 December, he was very quiet and failed to engage in any conversation. She said she wanted to draw up a strict intervention plan to ensure that he remained out of trouble, but he remained uncooperative.

### **HMYOI Feltham – 27 December 2008**

53. He was arrested again on 25 December for driving offences. He remained in police custody until going to court on 27 December. The court remanded him into custody at HMYOI Feltham A, for young people under 18. He spent his first period in prison custody, on remand at HMYOI Feltham A side (for young people under 18). Over the next couple of days he received a full induction on Bittern unit, which is the induction wing. He was interviewed by staff and, in response to routine questions, said that he had no thoughts of harming himself. His only concern was that he might have a “problem with boys from Feltham, but he will only defend himself if he is punched”.
54. Governor A manages the first days in custody services for young people and young adults at Feltham. He oversees the reception, first night and induction process for both sides of the prison. He explained that when a young adult arrives at Feltham, a cell sharing risk assessment (CSRA) is carried out. The assessment is reviewed before the young adult can move from the induction unit to a residential wing. The man’s CSRA stated that he should be allocated in a single cell and he repeated that he had no thoughts of wanting to harm himself.
55. He was assigned Officer A as his remand review plan officer/offender supervisor. At interview with the investigation team, she said that her role was similar to a caseworker for young people. She manages the young people whilst they are in custody, meeting them regularly to address any issues or concerns and liaising with the YOS regarding remand or sentence planning meetings.
56. In the officer’s Initial Review Plan meeting (form dated 30 December), she noted that he was getting on “fine” in prison and had no concerns. She also wrote “At present there are no concerns with him being a risk to himself, to others or from others”.
57. He was involved in a fight with a prisoner on 12 January 2009. Mediation was attempted but failed as the prisoner and two others said they disliked him. A security report was filed on 14 January and staff were told to keep the three prisoners apart from him to prevent any further fights. No further information was recorded relating to his safety at this time.

58. On 15 January, he reported that he had been bullied by two other prisoners whilst attending the gym. The anti-bullying procedures were invoked against the two individuals.

### **Back in the community – 20 January 2009**

59. A bail application was made for him and he was later released on 20 January. The court imposed an Anti-Social Behaviour Order upon him, prohibiting him from associating with other known peer criminals and entering particular areas of Kent.
60. The YOS Officer continued to support him to address his offending behaviour. She referred him to the Child and Adolescent Mental Health Service (CAMHS). He agreed to cooperate but, after about four sessions, his appointments were discontinued because the mental health worker retired and was not replaced. The investigation team tried to obtain copies of any CAMHS reports written on him via his mentor. However, despite requesting reports from the Social Services, they were unable to provide any documentation.
61. Around two months after being released from Feltham, he was arrested on 21 March and charged with the offence of robbery committed in February. He subsequently appeared before the Youth Court and was remanded back into prison custody at Feltham. He was fully inducted into the prison and staff again noted that he had no thoughts of wanting to harm himself.

### **Return to HMYOI Feltham – 14 April**

62. He appeared at court on 14 April and was found guilty. He was returned to prison custody at Feltham.
63. On 28 April, he went back to court and was released from custody but immediately re-arrested on two further charges of violent robberies in February and March. The YOS Officer said that he was very unhappy about this. He was held in police custody overnight and returned to Feltham the following day, 29 April. He went through the reception screening process again. It was noted that he had just left Feltham and had no problems about returning. He had no history of self harm and stated "he would not harm himself".
64. He remained on remand at Feltham and attended court and police stations on a number of occasions. Whilst he was in custody he was given another YOS Officer. She visited him each month to check his well-being and progress and attend remand planning meetings with Officer A. On each occasion a Remand Progress Review plan was completed. The officer also spoke to the man's mother who was able to contribute to his support and care. He received numerous visits from friends and family. After he had been in custody for the Christmas period, his mother said that she saw an improvement in his behaviour and he began to engage better with the YOS staff.
65. YOS Officer A interviewed him and completed the Asset, dated 24 April and 30 June. It gave details of his offending history to date, his involvement with social

services and his difficult upbringing. It was noted that he had not engaged with education although, whilst in Feltham, he was receiving one to one tuition and responding well. He said that his use of alcohol and cannabis had declined, both of which influenced his behaviour and distorted his ability to make sound decisions. He described himself as feeling frustrated and worried. He was angry with the criminal justice system and adamant that he did not commit the robbery. He was also angry that he had been placed into care when he was younger. He showed no thoughts of wanting to harm himself to her which was noted in the Asset.

66. He was seen by a member of the Feltham chaplaincy team on 23 June. The chaplain noted in his wing history sheet that he was “concerned about his anticipated sentence. Not in a relaxed mood. Would be happy for another visit in the future”.
67. Officer A and YOS Officer B assessed and held remand meetings with him over the months. Initially his behaviour was poor and he was involved in several fights and altercations. He was the subject of security reports, adjudications (which are breaches of the Prison Rules) and subsequent loss of privileges. Consideration was given to whether he could be a victim of bullying but this was not thought to be applicable.
68. He settled into the regime and began going to daily workshops to improve his literacy and numeric skills. He also went to an art workshop. His behaviour was reported to have improved after some months, compared to when he first arrived. Officer A described him as confident, especially as he was now very familiar with Feltham A.
69. During August, his behaviour returned to being disruptive and abusive to other prisoners and staff. Staff believed that he was “too comfortable” on the unit. He was described as taking advantage of staff and unable to keep out of trouble for long periods of time. This affected his attendance at education classes.
70. On the morning of 3 September, he refused to go to court and was placed on report for his general conduct. He had a number of Incentive and Earned Privilege (IEP) reviews and was put on the basic level, losing privileges such as association time with other prisoners and canteen (snacks and tobacco). The senior officer on the wing noted that he was a young man who needed a lot of support and direction and so he was set a number of targets to improve his behaviour.
71. Prisoner A was interviewed by the investigation team. He first met the man when they were in the care home in Birmingham. They were friends but he said that they “had their ups and downs”. After the man left the home they did not see each other for many years, until they happened to meet again in London during 2008. Although they resumed their friendship, they had a disagreement and did not speak for a number of months until meeting again in February 2009. (The man’s contact with the prisoner and other prisoners was mentioned by his family and so my report mentions incidents in which he was involved.)

72. When he committed the robbery in February 2009, the prisoner said that he was with him. He was charged by the police and he believed that the prisoner had “grassed him up to the police”. Approximately one month later (March 2009), the prisoner was committed into custody at Feltham, young adult side (B side) for a different offence. He thought that the man was already in Feltham but on the side of the prison for young people under the age of 18 (A side).
73. Although prisoners on the A and B side of the prison are generally kept apart, there are occasions en-route to education, visits or the gym, when they transfer through a communal corridor. The prisoner said that on one such occasion, he came across him and they had a fight. The prisoner then began hearing rumours from other prisoners that he was a “snitch and a grass”. He was annoyed and approached him in the chapel (another area where A and B prisoners can come into contact with each other) numerous times about this. He said that they eventually settled their differences and, from around March/April, were friendly again.
74. In spite of this, a number of SIRs were submitted by staff in August and September surrounding the conflict between the prisoner and the man. The prisoner alleged that the man had raped his sister and various threats were made between the two, at the intermittent times they came into contact with each other. Staff already aware of their dislike for each other, took appropriate action to reduce any conflict that occurred.
75. On 8 September, YOS Officer A went to the Youth Court and was told that the man’s trial had been suspended indefinitely as two other cases of robbery had been identified. The details were being investigated by the police.
76. Officer A told the investigation team that she saw him on 20 September, the day before he went to court, and he said that his solicitor would be applying for bail but neither believed that it would be granted.

#### **Release on bail – 21 September**

77. He appeared at Crown Court on 21 September and was granted conditional bail. YOS Officer A described him as overjoyed at being released as it meant he would not be in custody on his 18<sup>th</sup> birthday and would be able to enjoy it.
78. The mentor had visited him a number of times whilst he was in custody and after his release on bail. He saw him again on 14 October, the day before he was sentenced. They talked about his court appearance and the fact that his barrister had told him that there was a possibility he would be found guilty and receive a significant sentence. He did not believe that he would be convicted.

#### **HMPYOI Feltham – 15 October**

79. He went to Crown Court on 15 October. He was found guilty of grievous bodily harm, robbery and attempted robbery. He was remanded back into custody at Feltham to return to court on 13 November for sentencing. The court adjourned

so that a pre-sentence report could be prepared by the YOS. The purpose of the report is to inform the court about the circumstances of the young person including background information about their life, family and relationships, education and lifestyle. The reports highlight risk factors to their offending and make recommendations about the most appropriate sentence.

80. As he was now 18 years old and an adult, he was taken to Feltham B (young adult side) instead of Feltham A. He completed the reception and first night screening and interview and no concerns were noted. He was seen by the reception nurse who wrote "back into centre no new issues". He was considered suitable to share a cell, given a smokers' pack and a free telephone call. An "Initial Custody Interview" was conducted which looked at any "Risks of Self Harm". Again, no concerns were recorded for him and he was taken to the Mallard unit (for second stage induction, remand and convicted wing).

### **HMYOI Reading – 16 October**

81. For reasons which are unclear, he returned to court the following morning (16 October). He was assessed by the nurse in reception and deemed "fit for court, no complaints". After his court appearance, he was transferred to HMYOI Reading. The investigation team found no reason why he was transferred to Reading rather than returning to Feltham.
82. When he arrived at Reading, he completed the usual reception screening process which included a Well Man clinic and he was examined by the nurse on duty. His health was described as "normal" although he said he had a sore throat and a broken finger. He also admitted smoking cannabis within the last week. He was referred to the prison doctor, who noted that he had been involved in a fight but had no injuries. No concerns were raised during the cell sharing risk assessment (CSRA) and he was inducted into the prison.
83. As part of his induction, on the morning of 19 October, he underwent a mental health screening. The clinical reviewer described the screening as a structured questionnaire. It was conducted by Nurse A and divided into five sections covering general information, risk, alcohol use, drug use and mood. He scored the following:

Risk	0/10
Alcohol	2/20
Drugs	2/16
Mood	1/22 (the denominator of 22 should be 24, however there appears to be an error within the form)

84. The total score of 5/70 is below the cut off point, which is 36, which triggers consideration at the "high dependency" meeting. The outcome at the conclusion of the screening included the advice to contact the Listener service and the Samaritans if required, and referral to a substance misuse nurse. No further follow up was thought necessary.

85. YOS Officer C was interviewed by the investigation team in relation to the pre-sentence report she completed for him, dated 10 November 2009, at the request of the court. She had also completed an Asset document. She completed the reports in the absence of YOS Officer A, who was temporarily away from the YOS office. He remained in Reading between 16 October and 13 November. She interviewed him on 28 October prior to writing her report. She also contacted his mentor and spoke to his mother to gain more information.
86. This meeting was the first time that she had met him. She described him as open and co-operative throughout their discussion and she thought that he seemed quite happy. She said that he was positive and very friendly. He denied any thought of harming himself and the only vulnerability which she was aware of was his learning difficulties. She assessed that he was at risk from the "behaviour of other people". He was also likely to be vulnerable because of the disrupted care arrangements and his excessive use of alcohol. These were issues that he had encountered from a young age.
87. She noted that he had been trying to make positive changes in his life but he had experienced difficulties. He was angry and his behaviour was aggressive which was demonstrated through his offending. However, she judged that these tendencies appeared to lessen as he was getting older and maturing. She said that he knew what he needed to do to improve his life but needed support and guidance to help him achieve it.
88. She thought that inevitably he would receive a custodial sentence. He had committed serious offences and he was aware that he might receive a long sentence. As such, he was concerned that he would be away from his family and his girlfriend, although he spoke positively about things he could do on release from prison. Throughout the interview, he raised no concerns with her about being at Reading.
89. On 12 November, a risk of serious harm assessment (ROSH) and risk management assessment were completed by the YOS. Both tools are used in the management and risk assessment of young persons. Neither highlighted any risk concerns about him. The following was noted:
- "Areas to focus on managing his anger, working around his alcohol use, helping him learn pro-social skills, support and referring him to probation as soon as he comes out."
90. He appeared at Crown Court on 13 November for sentencing. No concerns about his physical or mental health were noted on the Person Escort Record (PER) form which accompanied him from Reading to court.

### **Return to HMYOI Feltham – 13 November**

91. He was sentenced to five years imprisonment and transferred to Feltham B. YOS Officer A went to court and explained to him that, as he was now 18 years of age, responsibility for his sentence management would be transferred from

the YOS to the Probation Service and a probation officer would be allocated. She thought that he took the news of his sentence well as he had previously been told by his solicitor that it could be between seven and nine years. The mentor told the investigation team that the man had a good relationship with YOS Officer A and he thought that he would struggle to build up the trust with his probation officer.

92. He arrived at Feltham at around 6.00pm. He went through the reception and induction screening process. It was noted that he had received a five year sentence but “expected much more”. No concerns were noted and he gave no indication that he was thinking about harming himself. Due to the nature of his offence, his CSRA was assessed as “medium” risk.
93. He was examined by Nurse B who also noted that he had no thoughts of self harm, no immediate health concerns, and was fit to share a cell. He repeated that he had expected a lengthier sentence. As is usual for new prisoners at Feltham, he was checked hourly during his first night in custody. No concerns were recorded by staff.
94. Officer A was unaware of the circumstances surrounding his bail conditions in September, when he had been released. She said that usually when a young person is about to make the transition from the young person to the young adult side of the prison, a planning meeting takes place with his YOS. The prisoner then has a handover where the young adult side of the prison is explained. She was also unaware of his return to Feltham and therefore she did not know how he reacted to his five year sentence. However, she knew that he had a number of previous convictions and thought that he seemed prepared for a lengthy sentence.
95. On 14 November, a security information report was raised. It noted that the prisoner who he had fallen out with previously knew that he had returned to Feltham. Staff believed that, if they came into contact with each other, there was a high risk of violence and “Prisoner A might incite others to join in”.
96. Two days later, on 16 November, his CSRA was reviewed and a cell sharing risk minimisation plan (CSRMP) form was completed. The CSRMP has to be completed within a week of a prisoner’s arrival if they are identified as being medium or high risk for cell sharing. The aim is to reduce the prisoner’s CSRA level and make recommendations for the prisoner to attend programmes, for example to address aggressive behaviour. The form noted that he did not get on with his cellmate and was assessed as “increased risk” to others. He said that he “will only [use violence to] defend himself”. He asked if Prisoner A was in custody at Feltham and said that he wanted to “kill him”. His CSRA was recorded as high/medium with staff commenting that “[he] poses no more risk now than he did previously”. The investigation team interviewed two of the three members of staff (SO A and Governor A) who signed the CSRMP but neither could recall the detail of their involvement.
97. SO A was the unit manager and responsible for dealing with any problems that arose around the Feltham B reception area. Because of his role, he explained

to the investigation team that his name appeared on documentation such as the man's CSRA minimisation form. He did not contribute to the assessments and did not recall speaking to him. Staff did not report any concerns about either the man or Prisoner A, whose name was mentioned on the CSRA minimisation form. He passed the form to Governor A for approval. The Governor said that the form raised no major concerns and, although he too had no recollection, he said that he would have spoken to the man about moving to another cell. His prison records contained no further information to suggest that any incidents occurred with his cellmate.

98. The SO said that there was little physical difference between the layout of Feltham A and B and the main difference was the atmosphere. He described Feltham B as calm and mature whilst Feltham A, due to the younger prisoners, was more prone to disruptions with alarm bells and prisoners fighting. He said that Feltham had a very effective anti-bullying policy in place and staff went to great lengths to locate prisoners in a place of their choice where they felt safe. Sometimes this meant keeping a prisoner on the Kingfisher unit (first days in custody unit) for a longer period of time.
99. On the morning of 17 November, Officer B printed a list of young adults who were eligible to transfer from Feltham. During interview for this investigation, the officer explained that there was pressure to free up spaces on the young adult side of the YOI because of national prison population pressures. As such, only young adults with a court appearance scheduled in the following three months could remain at Feltham. Once a young adult was sentenced, it was customary for them to transfer to another establishment. There were six young adults on the transfer list on 17 November, one of whom was the man.
100. The Population Management Unit in the National Offender Management Service (NOMS) manages prisoner movements around the country. Every day, they inform each prison of the spaces which are available. The officer told the investigation team that Feltham prisoners are routinely allocated spaces in Portland, HMYOI Rochester and HMYOI Glen Parva. Of these three YOIs, only Portland accepts young adults with sentences of five years or more. He showed my investigator the list of young adults for transfer on 17 November. Five of the six young adults on the transfer list on 17 November had sentences of five years or more and they were all (including the man) allocated to Portland.
101. To assist the allocation of a young adult, the allocation officer completes the Initial Classification and Allocation of Young Offenders form, (also known as ICA2). The officer completed section one of the form for him, noted that he was allocated to Portland, and signed the form. The officer explained that the remaining five sections are normally completed by the Offender Management team. However, those parts of his form were left blank. The form should have included sentence details, risk classification, any history of concerns about the young adult and information about their family circumstances that might inform the allocation decision. There is also space to record the young adult's reaction to his sentence and any factors to be taken into account when deciding on the allocation.

102. The man's had an offender manager. He interviewed him on 17 November, and completed the document Initial Custody Plan for Young Adults. The plan is used to address a prisoner's offending behaviour. He recorded the following:

"Meeting with him to complete his LISARRT (London Initial Screening and Referral Form) and to compile an initial custody plan. He had problems reading and writing that needs addressing by education."

The investigation team spoke to the offender manager but he had no recollection of meeting him.

103. Once the allocation decision is made, the allocation officer tells the young person where they will be transferred. Officer B said he could not remember whether he or another member of his staff informed him of the decision. However, he said that he normally speaks to young adults in the afternoon either in their cells or a quiet room. If the prisoner is worried about transferring, he explains how to ask for assisted visits and make an application to transfer closer to home. He had no record that he had any such concerns. He signed the allocations pro-forma to confirm he understood why he was going to Portland and agreed to the transfer.

104. The next morning, 18 November, Nurse C completed a healthcare transfer form. She explained to the investigator that healthcare receive a list every evening of the young adults who are to be transferred the next day. Overnight, their medical records are retrieved and prepared for transfer. She said that she looks through the record to identify any medical issues which should be resolved before the transfer. She also assesses whether any medication should accompany the young adult and if there are concerns to be drawn to the attention of the receiving establishment.

105. She completed his transfer form on 18 November. She had not met him before and she based her assessment on the information in his medical record. He had no outstanding medical or mental health issues and needed no medication. She noted that he had "no suicide or self harm risk issues". She explained that she took Nurse B's assessment on 13 November, in which no concerns were highlighted, into consideration. As there were no other significant events recorded in his record, she was satisfied that the nurse's assessment was still accurate and that he was fit to transfer.

106. She explained that a healthcare professional is present at reception as young adults are taken to the escort van. The nurse could not confirm whether she observed the transfer on 18 November. However, whichever colleague was present would speak to anyone who was upset and any serious concerns would be discussed with the senior officer. There are no records that he was upset to be leaving Feltham, or that any concerns were raised with the reception senior officer.

107. Operation Support Grade (OSG) Officer A was interviewed by my investigation team. She works in the reception area and sees prisoners as they arrive or

depart. If she had any concerns, they would be addressed by herself and, if necessary, the senior officer. She had come into contact with him several times in reception and she thought that he generally appeared okay. On the day when he was to be transferred to Portland, she was told by an officer (who she could not recall) that he had been held alone in one of the reception holding cells because he refused to transfer to Portland. Other prisoners waiting to board the escort vehicle were held in another room.

108. Usually a Governor comes to reception to speak to any prisoner who refuses to transfer to another establishment. The OSG told my investigator this was not necessary because she asked him about his concerns. He confirmed that he was okay and said that he had no issues with any of the prisoners at Portland. He was concerned about his family being able to visit him because of the long distance from their home. She said that she tried to reassure him that if he did not receive many visits at Portland, they could be accumulated which meant that he would return to Feltham for “accumulated visits”. He seemed to accept her reassurance.
109. She said she was unsure as to whether he shared his concerns with any other staff. She said that it was common for Feltham prisoners to worry about the distance to Portland. She had compiled an information booklet, including details about Portland, which was kept in the holding rooms. The reception checks normally take about 45 minutes which gives them the opportunity to read the booklet whilst they wait to leave. Unfortunately, she could not find the booklet to show the investigation team and she was not sure when she first introduced it.

#### **HMYOI Portland – 18 November**

110. Prisoners are escorted to courts, police stations and other prisons by a private security company, G4S, which is contracted by the National Offender Management Service. He travelled in the escort vehicle to Portland with five other prisoners from Feltham. Two of the prisoners made themselves available to be interviewed by the investigation team.
111. Prisoner B confirmed that, as well as travelling in the same vehicle, he also knew him at Feltham. He had not seen him for a while until they met whilst being transferred. He thought that his mood appeared to be okay although he mentioned that he felt Portland was too great a distance away, especially for his grandmother, to be able to visit him. Prisoner B did not know the other prisoners, but he said that no one had any problems on the journey. He added that, when he saw him later at Portland, he seemed happy and did not appear “depressed”.
112. Prisoner C told the investigator that he first met him in the reception area whilst they were undergoing their checks before departing for Portland. They had a general chat which continued in the escort vehicle, with many of them talking about how far Portland appeared to be. (Over the next couple of days, he talked with him during association time. They spoke about prison life and played pool and he described his mood as good.)

113. The escort vehicle arrived at Portland at around 1.10pm. Prisoner C said that the reception staff were supportive. He noticed nothing in his demeanour that caused him to be concerned about his welfare. No concerns about him were noted on the PER which was handed over to Portland reception staff. He then proceeded through the usual reception screening process.
114. At interview with the investigator, Officer C explained that normally Portland received prisoners from Feltham on a Thursday and Reading on a Friday and some of the other prisons throughout the week. He was on duty in reception when the man arrived, although he could not recall him personally.
115. As is usual, the officer used the Portland reception questionnaire when he interviewed him. The questionnaire is designed to elicit any information about an individual's wellbeing so that further support can be given if required. He was asked a range of questions about his physical and mental health. He would have had his PER and core record to assist his questioning. Throughout the interview he raised no concerns with the officer and told the officer that he did not consider himself to be vulnerable. The officer said that, being ACCT trained, he observed the behaviour of new prisoners and assessed whether they needed any additional support.
116. Whilst he was carrying out his duties, another officer arranges their prison clothing and property. The prisoner is photographed and an identification card made up. The whole process takes about ten minutes. Having gone through the reception process, he was placed in the second holding cell in the reception area.
117. At interview with the investigation team, Prisoner D at Portland said that he worked in reception and on Grenville house block as a Greeter. (Grenville is the induction wing.) His role was to greet all the new prisoners to help them settle into the prison by answering any questions and allaying any fears they may have. He explained that one of the rumours he had heard many new prisoners express was that Portland was known as "Shank City" (a term used to describe knife attacks). He told my investigator that he would quickly dispel this as a rumour. In his view, Portland has a lot to offer prisoners.
118. He introduced himself to the man when he arrived. He was "talkative and quite bubbly" and seemed fine. The prisoner also worked in the induction wing kitchen and explained that he came into contact with him quite often. During their conversations, he asked the prisoner to write letters for him. Although he could not recall the exact days, the prisoner was allowed by staff to visit him twice in his cell to help him. He said that they often ended up laughing and joking. He had shown pictures of his family to the prisoner who had no concerns about him during any of their interactions.
119. Nurse D worked at Portland as an agency employee approximately twice a week. At interview with the investigation team, he said that the prison reception area was always staffed by a qualified nurse. On average, the nurse would spend about 15 to 20 minutes with each prisoner. If a prisoner was subject to

self harm monitoring when they arrived, or had a severe psychiatric history, the nurse would spend longer with him.

120. The nurse was one of two nurses on duty in the reception area and they examined the prisoners in adjacent, private, rooms. When he conducted the reception screening (entered on the computer at around 6.56pm), he had his medical record from Feltham to refer to. He asked him a number of questions, observing not just his verbal responses, but also his non-verbal and body language. He had no long term medical conditions, was not taking any medication and denied having any psychiatric or self harm history. Following the assessment, he had no concerns about his demeanour. His CSRA was noted as "low". Although he had no immediate medical needs, he was given the option to see the prison doctor the following morning, which he declined.
121. Nurse E entered his assessment on the computer system. This was because at the time there was only one terminal in reception which was linked to the healthcare system. As she was already entering details of new prisoners when Nurse D had completed his examinations, she offered to assist by entering the data which he had collected from the new prisoners.

#### **After the reception screen**

122. Although Officer D worked within the Grenville house block, he was in the reception area when the man arrived. He reviewed his prison records and used them to complete the CSRA. The officer noted that he had previously abused alcohol and had been involved in fights and assaults on other prisoners whilst at Feltham. For this reason, he noted his CSRA as "Medium", meaning "No immediate risk, but situation will need to be reviewed regularly". The officer knew that he was not being supervised by the ACCT monitoring procedures. He confirmed that, once a prisoner completed their reception screening, they are taken to the induction unit.
123. After taking him to Grenville house block, the officer completed the document "Grenville 1<sup>st</sup> Night Officer Questionnaire" with him. He confirmed that he was not taking any medication and denied having an alcohol problem. He said his family did not know that he was at Portland, something the officer said could be rectified by a telephone call after he completed his reception screening. In response to the question "can you read and write", he said that he struggled.
124. When interviewed, the officer only had a vague recollection of him. He asked him whether he had a history of harming himself and any mental or physical health problems. He said that he had no current thoughts of self harm and had no other problems. He had been trained to use the ACCT procedures to support prisoners at risk of harming themselves. He said that the man gave no cause to consider opening the procedures. He did say he was concerned about the distance from the prison to his home. There was a problem with his telephone personal identification number (the PIN, which is used to access the telephone network), although the officer could not remember what it was. Nonetheless, he telephoned the man's mother and allowed him to speak to her

to tell her where he was. At his request, the officer also spoke to his mother to explain where the prison was and the arrangements for visiting.

125. He spoke to the officer for between 15 and 30 minutes. He was offered a shower, smokers' pack (tobacco), telephone call and television aerial. The officer's last question to him was whether he had any concerns that had not been covered during the interview, to which he replied that he did not.
126. He was allocated to cell number eight on the third landing of Grenville. The cell contained a Portland information pack which gave details about all the departments such as healthcare, Samaritans and chaplaincy. No issues were reported during his first night at Portland.

#### **Thursday 19 November**

127. The regime for new prisoners on their second day at Portland is to visit the clothing stores to collect their prison clothing and then be assessed by healthcare. This process is done as a group, and prisoners do not return to the induction wing until they have all had their health checks.
128. Having collected his clothing, he went to the healthcare wing for a secondary health screening assessment at around 11.13am. It was carried out by a Healthcare Assistant (HCA). When interviewed by the investigation team, her memory of him was vague, but she did remember that he presented no immediate concerns to her. She had his medical record in her possession when she interviewed him. She engaged in general conversation with him about his physical and mental well-being. Nothing of concern was highlighted, although she made a routine referral to the doctor for the following week because of an old finger injury. His weight, height and blood pressure were all measured.
129. Each prisoner is asked whether they misuse any substance or alcohol and, if necessary, they are referred to the Counselling, Assessment, Referral, Advice and Throughcare services. (The CARATs team provides non-clinical treatment for prisoners with substance misuse problems.) He admitted using cannabis in the past but did not want to be referred for any treatment.
130. The HCA said that if he had any issues which she was concerned about, she would have referred him immediately either to the doctor on duty or a registered mental health nurse. She said that most prisoners were mainly concerned about the distance from home, which could result in them receiving fewer visits.
131. The chaplain told the investigation team that he saw all new prisoners as part of his pastoral duties. He visited him in his cell late that morning and spoke with him for about five minutes about any concerns and his family and support network. He provided him with leaflets about the chaplain and support services in the prison. He did not think that he was struggling because he was in a new prison or that he would harm himself. He said that he would immediately have passed any concerns to the wing staff, as well as noting them in the pastoral journal.

132. Officer E was appointed as his main personal officer. He meets his prisoners regularly to help them with any concerns they might have. He introduced himself to him over the lunch time period whilst he was eating his lunch in his cell. They had a quick chat about Grenville and its function as an induction wing. He was “co-operative”, understood what was being said to him and raised no concerns. (This is in contrast to the family’s comment that another prisoner told them that he alerted the officer to his anxieties about him.) The officer told the investigation team that because of duties which took him away from the wing and annual leave, he did not come into contact with him again.

### **Friday 20 November**

133. On Friday, prisoners on Grenville house block do not have association. They are unlocked at various times throughout the day to collect their meals, but otherwise remain in their cells all day. If a prisoner wishes to use the telephone, permission can be sought from staff and is usually granted. No concerns or requests to use the telephone were recorded about him.

134. At interview with the investigation team, SO B explained that he was in charge of the day to day running of the induction wing. The SO had no direct contact with him but he was aware of him for two reasons. Firstly, he completed his cell sharing risk minimisation plan (CSRMP) which is required for all prisoners identified as medium risk on their CSRA. He was assessed as medium risk because he abused alcohol and had been involved in fights at his previous prison. The SO recommended that he should be referred to the Controlling Anger and Learning to Manage (CALM) programme and Counselling, Assessment, Referral, Advice and Throughcare services (CARATs).

135. Secondly the SO was involved as his name was flagged by the security department. He was informed that, during routine monitoring of prisoner post on the Grenville unit, a letter from Prisoner E had been examined. He referred to the man, saying that he was upset to see him at Portland, and referred to having fallen out when they were at Reading. The SO said that staff were concerned about how they would interact when they met on the wing.

136. The prisoner was released from prison shortly after the man’s death and was not interviewed for this investigation. He was however interviewed by Officer F immediately following the death. He confirmed that he shared a cell with him at Reading for about a month. He said that they had a good relationship and he would write all his letters for him. However, just before the man left Reading, they had an argument and parted on unfriendly terms. When he saw him at Portland, he was unsure about how he would react, especially as in his words “going to Feltham, sometimes going there can drive you nuts and make you different”. However, he approached him to say that he wanted to be friends and so they sorted out their differences. He told the prisoner that they “needed to stick together on association”. They talked about his five year sentence, and the prisoner said that he did not appear overly concerned about it.

137. The SO said that no concerns were reported about him that day.

## Saturday 21 November

138. Having told the chaplain that he was Catholic, he went to the Roman Catholic mass on Saturday morning at around 9.15am. He met Roman Catholic Chaplain who informed him that she would visit him later for a general chat. She went to see him in his cell later that morning. She described him as well mannered and she was not concerned about his well being. She asked how he was and whether he would like to come back to the chapel to discuss “a way forward” for him following his fairly lengthy prison sentence. He seemed happy with this suggestion and they agreed that the meeting would take place during the following week.
139. Prisoners have their lunch between 11.30am to 12.30pm, and eat in their cells. At the weekends, they are unlocked for association from 1.45pm and returned to their cells by 5.30pm. (On weekdays, except Friday, prisoners have evening association from around 5.30pm to 7.30pm.)
140. Prisoner telephone calls are recorded at Portland, but they are not monitored simultaneously. It was only after his death when staff realised that he telephoned his mother’s house at 2.29pm. He spoke with his grandmother (known as his Nan), mother, brother and girlfriend although the majority of the call was with his girlfriend. He made no mention of harming himself throughout any of the conversation. He knew that he would only serve half of his five year sentence and his girlfriend referred to it being 26 months which he described as a “long time”. He said that he could telephone her anytime and intimated that he intended to do some of the prison courses on offer. He described his contact with staff and prisoners as good and said that he was not getting involved in any trouble. He would however have preferred to remain at Feltham. The telephone call lasted 23 minutes and 31 seconds.
141. Prisoner C spoke with him during association on Saturday. (In his interview he said this was between 5.30pm and 7.30pm, but it was likely to have been earlier as weekend association ends at 5.30pm.) He played pool and used the telephone to call his family. The prisoner was aware he had spoken to his grandmother. He said that his mood did not change after the telephone call or throughout association. He had been “jolly” and was “laughing” in their conversations. This was confirmed by Prisoner B, who said he seemed okay during association and saw him “laughing”.
142. Prisoner F was interviewed by the investigation team. He worked on Grenville as a Listener and was also a Greeter in reception when new prisoners arrived. He believed that these schemes worked well to support prisoners. He described the induction wing as “good” and “clean” and he felt that the staff treated prisoners fairly. In his opinion, bullying was not an issue on the wing. He had little contact with him, but when he saw him during association periods he thought that he “seemed perfectly happy”.
143. Prisoner E was one of the prisoners who the man talked with during association. They played pool and he “cheered” him up. He asked the prisoner

if he would write another letter for him on Sunday, to which he agreed. The prisoner said that he gave him no indication that he was worried or thinking about harming himself.

144. Prisoner D had brief contact with him during association, about five minutes before they were locked in their cells. He talked about what he wanted to do after he completed his sentence and appeared to be in a good mood. The prisoner said that he appeared to have settled into Portland well and he was mixing with the other prisoners.
145. Shortly after 5.30pm when prisoners were locked in their cells, Prisoner D (who was still unlocked because he worked as a cleaner) went to visit him to make sure that he was okay. He said he was fine and the prisoner returned to his cell.
146. Officer G was his second personal officer. She told the investigators that she normally introduced herself as a personal officer within five days of a prisoner's arrival. Due to his short period at Portland and her annual leave, she did not introduce herself formally and they did not have a one to one meeting. She came into contact with him during meal and association time when he did not come to her attention in any adverse way.
147. OSG A was on duty that night on Grenville house block. She came on duty at around 8.20pm and received a handover from the day staff when no problems were reported. One of her first tasks is to conduct a roll check which, she told the investigator, was at about 8.30pm. There were no problems or concerns when she checked the occupants in each cell on the wing.
148. The OSG's role is to patrol the landings during the night and make sure that everything is satisfactory. Any prisoners who are being monitored by ACCT are checked individually at agreed intervals. The OSG also carries out pegging duties, meaning that every half hour they patrol the landings, recording their progress on an electronic device at the end of the house block. During pegging checks, staff only open a cell observation panel if there is a problem such as loud music or the light being on in the early hours of the morning. She reported no problems during her night shift.
149. Nelson house block is next to Grenville and OSG B was on duty there. The two blocks are separated by gates which are left open during the night so that they become one continuous "block" and staff can see from one to the other. The Nelson office is on the "twos" landing (first floor) and the Grenville office is on the "ones" landing (ground floor). The OSG described the distance between the two house blocks as very short.
150. Portland does not use a specific code system in an emergency. OSG A said that, if an emergency occurred and she needed assistance quickly, she would alert others by shouting and/or pressing the emergency button on her radio.
151. Prisoner G was in the cell next door to the man and he was interviewed by the prison security officer, a PO after his death. The prisoner said that he arrived at

Portland the day after him. They had not talked to each other but he described him as “a nice bloke who just wanted to “do his bird” (meaning to complete his prison sentence). He was “Not a hard nut but not someone that was being bullied either. Just normal.”

152. On Saturday night, the prisoner said that it was quiet on the wing as everyone was watching television. However, just before midnight, he heard a “thump” sound, which he said was similar to a cup dropping off a table, and believed that it came from the man’s cell.

### **Sunday 22 November**

153. No concerns were reported during the night by the OSGs on either Grenville or Nelson house blocks. OSG A confirmed that the man did not press his cell bell for assistance. Just before 6.30am, both OSGs went to conduct their roll checks and OSG A began to check the prisoners on Grenville.
154. When she reached his cell, she opened the observation flap and looked inside. She saw something hanging down from the window and thought that he was playing around. She shut the flap, but quickly re-opened it and realised that he was hanging from the window bar at the back of the cell. She immediately shouted “emergency” to attract OSG B’s attention.
155. OSG B responded immediately to her shout for assistance. She had started her check near to Nelson house block and was close to where OSG B was standing although on the next landing up. He ran up to the “threes” landing (second floor) to join her who told him that a prisoner was hanging in the cell. He looked through the observation panel of the cell and saw him hanging.
156. Whilst he was doing this, she used her radio to contact staff in the Control Room to request further assistance. She broke the seal on her pouch to obtain the cell door key. (Sealed pouches containing a cell key are carried by night staff and are used to gain entry in an emergency to attend to a prisoner who is in danger.)
157. The OSGs said that they went into the cell within seconds. OSG B jumped on to the bed to try to cut the ligature with his ligature knife. OSG A attempted to support the body and take the weight off the ligature. His weight made it difficult for her to hold him up and so she swapped positions with OSG B. The ligature, which appeared to be made from bed sheets, was very thick.
158. Two officers were the assistant orderly officers (second in charge of the prison) on duty overnight. Officer H told the investigation team that it was a quiet night until they heard OSG A’s call for assistance over the radio at about 6.30am. They immediately made their way to Grenville, arriving in about 30 seconds.
159. Both officers went into the cell and found OSG A on the bed trying to cut the ligature from the window bar and OSG B supporting the body. Officer H used his radio to ask for an ambulance, recorded at 6.35am on the prison incident

log, and then helped OSG A try to cut the ligature. Officer I helped to support the body.

160. He was wearing his prison clothes. Once the ligature was cut, OSG B and Officer I lowered him on to his bed. His arms did not move and neither did his body bend. Officer H had an up to date first aid qualification and he described the body as stiff and his skin as mottled. He thought that rigor mortis was present. He had severe bruising around his neck where the ligature had been. Officer I examined him for signs of life but did not find any. Officer H noticed that there was a note on top of his toilet.
161. The orderly officer in charge of the prison was SO C. With his assistant they also responded to the OSG's call for assistance. The SO told the investigation team that when he arrived at Grenville house block, the four officers were in the cell. The man was still in a hanging position by the window but the officers had just cut the ligature and were lowering him to the bed. He assisted the staff to do this.
162. He said that the man showed no signs of life. He said that the staff discussed whether to attempt cardiopulmonary resuscitation but, given his condition, they agreed that it was unlikely to be effective. The paramedics arrived at 6.45am and they confirmed his death soon afterwards.

#### **Events after the man's death**

163. All the officers left the cell and waited outside. The SO returned to the orderly office to instigate the prison's death in custody procedures and contact the Governing Governor and the duty Governor. The police were notified and started to arrive at the prison at 7.40am.
164. The letters which Prisoner D had written for him were found in his cell. They were addressed to his "Nan" and "Mum". Neither indicated that he had any intention of taking his life. However another note and several drawings were found which he appeared to have written himself. The note was addressed to his girlfriend and said that he was sorry and "I just cant do it, miss you 2 much, sorry baby I love you so much got to go". It contained various drawings and statements including "RIP, I am free".
165. The Governor said that he was contacted at home at 6.45am by the SO, who told him that there had been a death in custody. Having ensured that the SO had begun to implement the contingency plan by contacting all the necessary persons, he immediately made his way to the prison. When he arrived he briefed the staff on duty and ensured that the cell was sealed to await the arrival of the police. His prison records were gathered to ascertain his next of kin details.
166. The duty Governor arrived at the prison soon after being contacted. He held a debrief meeting with staff at around 10.30am. The prisoners who were subject to ACCT monitoring were reviewed and offered support. At a later date, a Critical Debrief meeting was held and attended by a number of staff.

167. A SO went to see Prisoner E to return the letter which he had written previously that referred to the man and asked if he still wanted to send it out. The prisoner was very upset by his death and said that he had written the letter before they resolved their disagreement.

### **Contact with the man's family**

168. It was established that the man's next of kin lived near Feltham. Wanting to ensure that the news was broken to them as quickly as possible, the Governor contacted HMYOI Feltham to ask their family liaison officer to visit and inform them of his death. At about 1.00pm, staff at Feltham visited the family to break the news. They asked to speak with staff at Portland and the Governor spoke to the man's mother and grandmother. He told them about the circumstances surrounding his death and provided further information about the prison and what would happen next.

169. The family liaison officer (FLO) from Portland also spoke with the family around 2.00pm. She began to arrange to meet the family and provided further information, including the Coroner's contact details. She went to Grenville house block to find out any further information about him.

170. The following morning, 23 November, she spoke to his mother again to answer further questions about his death. Arrangements were made for his family to see him at the mortuary that afternoon. Both she and the chaplain arranged to meet the family there. Afterwards arrangements were made for his funeral, including offering financial assistance, as well as the return of his personal property. The family were offered a visit to the prison to view his cell and talk to any staff and prisoners who knew him.

171. His mother spoke positively about her continuing contact with the family liaison officer. She told the investigation team that the officer maintained regular contact and she found her to be kind and supportive.

172. The family visited the prison at a later date when they met the Governor and some of his staff. Afterwards, his mother told the investigation team that although she was not "surprised by the size of his cell", she was "disgusted by its state of repair". In particular the toilet was black with limescale and she described the cell as being in "squalor". She thought that these surroundings would have a detrimental effect on an individual's state of mind.

173. His grandmother told the investigation team that she took a telephone call from an unidentified prison officer on the morning after his death. The officer told her that the power to his cell was turned off at 2.30am and he was fine at the time. The family liaison officer confirmed to the investigation team that his grandmother had raised this issue and she explained that the electricity is switched off centrally at 2.00am. The prisons security manager said that prisoners on the standard level of the IEP scheme, like the man, have no power in their cells from 12.00am. The governor said that it is turned off from the outside and does not include checking the prisoner.

174. The post mortem concluded that the cause of death was hanging.

175. The funeral later took place on 8 December.

## **ISSUES RAISED IN THE INVESTIGATION**

### **Clinical care**

176. The clinical reviewer reviewed the man's community medical records and summarised his findings as follows:

"These notes have made clear that this man's developmental years were complicated by a number of adverse events. The information to hand provides a partial and patchy picture of a complex story. There is nothing in these notes to indicate the presence of any mental illness however there are indications that he showed evidence of a childhood conduct disorder of early onset. This is a risk factor for persistent social problems in later life and is associated with substance-misuse."

177. The clinical reviewer also noted several psychosocial factors which placed him at a higher risk of harming himself including his youth, gender and his separation from family. At no time during his period in custody did he show any evidence of any mental disorder to prison and healthcare staff. The reviewer said that he received a well structured mental health assessment on 19 October 2009, and his responses support the view that he did not have a mental disorder. He did not declare any risk factors to the staff when he was admitted to Portland.

178. He had contact with healthcare staff when he came in and out of custody and no risk that he might harm himself was highlighted.

### **The man's contact with the Youth Offender Service**

179. The YOS, and in particular YOS Officer A and the mentor, had a lot of contact with him. It was clear from their records that they built up a good relationship with him. He was seen regularly by the YOS and I believe that considerable effort and interventions were tried in an attempt to address his offending behaviour. This included engaging with his mother who also tried to support him and liaised with the YOS and the mentor.

### **The man's time at HMYOI Feltham**

180. The investigation team were told by staff at Feltham that it was common for prisoners in Feltham A to have issues with one another and some problems appeared to originate in their communities. Fights evidently occur more often in Feltham A than in Feltham B, where the prisoners are older and their behaviour is more mature. The majority of the man's time in custody was in Feltham A, where he was involved in a number of fights. This was evidenced in the large number of altercations recorded on security incident reports. As a consequence he often came to the attention of staff, had a number of adjudications and lost his IEP privileges on a number of occasions.

181. With regards to his safety, he became very familiar with life in Feltham and the staff believed that he was confident there. There was only one incident when he was bullied and I am satisfied that the staff took appropriate action. At no time did he show any sign that he might harm himself or felt vulnerable at Feltham.
182. He did threaten to kill another prisoner, which was recorded on a cell sharing risk minimisation form (CSRMF) at Feltham less than a week before he died. There is no evidence of any action taken on the matter or anything to suggest that they came into contact again. Incidents of this nature require a response from staff which should include implementing the violence reduction measures and completing a security incident report.

**The Governor at Feltham should remind staff that risks identified when completing cell sharing risk assessments should be followed up by the violence reduction measures and security incident reports.**

### **The man's time at HMYOI Reading**

183. The family asked the investigators to consider some aspects of his time at Reading including whether he was subject to 30 minute checks, who he shared a cell with, whether he was bullied by members of a rival gang, and if his cell was targeted for cell searches.
184. The prison and healthcare records for his stay at Reading are limited and they contain no concerns about him. The Governor and Security Officer said that he was not subject to ACCT monitoring and no incidents, including security matters, were reported. They also said that his cell was not targeted for any specific cell searches. The family also said that he wrote to his girlfriend from Reading, saying that he had not eaten for two days. His medical or prison records do not contain any information to suggest that he refused his meals.
185. His mother also said that a fellow prisoner had told her that he had been subjected to "aggressive cell raids" by officers using plastic shields at Reading and Feltham. If this type of force is used, it is the policy of the National Offender Management Service that it should be documented. The investigation team found no evidence that searches occurred or that force was used.

### **Being sentenced as an adult**

186. Staff at Feltham told the investigation team about the differences between the two sides of the prison. Officer A confirmed that, normally before a young prisoner moves to the young adult side, a meeting takes place with the young person, offender supervisor and the YOS. The young person is given a handover and told about the young adult side of the prison. Because he came back into custody after his 18<sup>th</sup> birthday, he did not receive the handover.
187. When he was sentenced for the first time as an adult, his YOS worker told him that his case would be handed over to the probation service. She explained

that the level of support which the YOS gave might well be reduced and thought this might have an impact on him.

188. There is no doubt that he was aware that he might receive a lengthy custodial sentence. This view was supported by his YOS worker, who said that his legal team also believed it. He did not voice any concerns to those closest to him. On the other hand, in his conversation with his mentor before his court appearance, he said that he did not think he would be convicted, which may have been his way of dealing with what looked like an inevitable situation.
189. His mentor was not at court when he was sentenced. He had built up a good relationship with him as his mentor and believed that he would have been shocked by his conviction and struggled to serve a long sentence. Furthermore, he said that the man may well have thought that he would serve his sentence at Feltham. He believed that the length of sentence and the transfer would have been a "great shock" to him who had got used to Feltham and coped there. Being told that he was to be transferred within 24 hours was a change that he thought he would not be able to cope with.
190. He told the investigation team that, although 18 years old, the man was emotionally immature. He was a young man "still working out his emotions, and growing up in the world and [finding] his place in the world". He felt he would have needed "a lot of time and support" to adjust and be able to understand how things were going to be, "in a world he had no idea about".

### **Transfer to HMYOI Portland**

191. The family asked the investigation team to consider his transfer to Portland which is further from his home.
192. Feltham transfers prisoners to HMYOI Glen Parva, Portland and HMYOI Rochester. Of the three, only Portland accepts young adults with a five year sentence. As this was his sentence, I consider that the allocation was reasonable and inevitable. The National Offender Management Service aims to locate prisoners near to their homes but a prisoner's specialist requirements have to take precedence over proximity. He was an adult, convicted at Crown Court and serving a sentence which Portland accommodated. Like any other prisoner in those circumstances, he was allocated to Portland.
193. However, I am concerned that he may not have had the opportunity to discuss any anxieties that his allocation might have caused him. The investigation team was told by his offender manager and allocation officer that they explain to young adults who are anxious about applying to move nearer to home and how to use the assisted visit scheme in the meantime. There is no evidence of either discussion with him. The interview to complete the Initial Classification and Allocation form (ICA2) form should have raised these issues. The form was partially completed by the allocation officer, who provided a copy of his signed acknowledgement of his allocation. However, the form is incomplete and there is no record of how he felt about his transfer or any information about his family situation that might have affected his allocation.

194. That this form, and I assume the interview, were incomplete was a missed opportunity for him to raise any concerns about being transferred to a prison which was some distance from his family. The form is designed to identify a prisoner's concerns about moving and it is important that it is completed satisfactorily.

**The Governor at Feltham should remind staff of the importance of completing ICA2 documentation to ensure that each young prisoner has the opportunity to voice any concerns about the transfer.**

### **Discovering the man hanging**

195. When he was discovered hanging, I am satisfied that the staff and ambulance responded quickly. However, rigor mortis was present and so any attempt to resuscitate him would have been futile. I believe that it would have been undignified for him and distressing for the staff to have attempted resuscitation when there were clearly no signs of life. The response by staff was in line with the guidance given by the National Offender Management Service.

196. The investigation team however were made aware through interviews that one member of staff that had attended his cell did not have current first aid training. I consider it best practice that uniformed prison officer staff who are usually the first responders to medical emergencies do have up to date first aid training which enables them to commence CPR. Portland also do not use radio codes which can distinguish between different types of emergencies. This has the benefit of providing staff with more information about what to possibly expect when they arrive at a cell in an emergency. Neither of these two issues raised caused any delay in staff attending to him when he was discovered. However, although I make no recommendations on the issues, I bring them to the Governors attention as matters which he might wish to review.

197. A note was found in his cell after he was discovered. Some care seems to have been taken when drafting the words and the sentiment expressed seems to be a farewell to a girlfriend and his family. The note suggests that he felt unable to face the prospect of a prolonged sentence and chose suicide as an escape.

### **Other family concerns**

#### The man's cell at Portland

198. His mother raised concerns about the condition of her son's cell and whether this may have contributed to his state of mind given the time he was required to spend in his cell. The investigation team viewed the cell whilst opening the investigation and did not consider the cell untypical of a standard cell on an induction wing. They did not see any broken furniture; however his mother said she noticed that a set of drawers and the television were broken when she visited the cell. Prisoners stay on the induction wing for a short period before being located more permanently on a residential wing.

199. The HMCIP report highlighted that, during their inspection, not all the cells and toilets were clean. It made the following recommendations:

- Cells on Grenville unit should be adequately cleaned for each new occupant.
- There should be a painting programme to ensure all cells are clean and free from graffiti. All toilets should be de-scaled. Staff should encourage all prisoners to keep their cells clean and provide them with sufficient cleaning materials.

200. The recommendations were made a short period prior to his arrival at Portland and are part of many areas identified by the HMCIP report to assist with improving conditions at Portland. Although the investigation team were told that prisoners are selected as “cleaners” on each wing and they have access to various cleaning materials which are safe to use in a prison setting, I remind the Governor of these recommendations and their implementation as soon as possible.

#### HMP Portland Induction Programme

201. The family raised concerns that the induction programme at Portland only begins on a Monday. This meant he had to wait four days for the programme to start and there appears to have been very little for him to do in the interim. They feel this is of particular concern in light of the fact that prisoners are of higher risk of suicide in the first few days of custody and also at increased risk if they have nothing to occupy themselves

202. Portland’s induction programme starts on Mondays. Friday is a full prison staff training day and normally a non association day. New prisoners will not be initially employed. He arrived on a Wednesday afternoon and so was not due to commence full induction programme until the following Monday. He was however reasonably occupied on his first two days in prison undergoing his reception screening, secondary health screening and collecting of prison clothing. In addition he had association, meetings with the prison chaplain and his personal officer.

203. From the evidence available, he was confined to his cell (like all other prisoners) without association for large parts of the day on Friday, his third day. Prisoners have reduced activities on Saturday and Sunday due to a reduced staffing level. The induction programme does not operate over this period. There was no evidence to suggest he was denied access to speak to staff during his stay at Portland.

204. In her last inspectorate report (September 2009), HM Inspector of Prisons also raised concerns about the induction programme, recommending that “The first week of the induction programme should be delivered as a rolling programme, making use of a full range of multi-media” and that “Prisoners should be unlocked when they are not actively participating in induction sessions”.

205. It is not possible to say with any certainty whether the outcome would have been different had he been more occupied during this initial period in custody. Based on the evidence available, I do not consider it likely that the earlier commencement of the induction programme would have had a significant impact on the time he spent in his cell (taking into account the time already absorbed by the initial screening requirements and limited association at weekends). I do not therefore consider, in this instance, that it would be realistic or reasonable to make a recommendation above that already suggested by HMCIP to improve practice in this area.

#### The man's fears about his safety and that of his family

206. The family asked the investigators to consider whether he was afraid about his and his family's safety. The investigation team reviewed the Security Intelligence Reports (SIRs) and found no direct evidence to suggest that his family's safety had ever been compromised. However amongst the reports, there is one reference to his mother on 30 June which may be the incident she refers to when she believes that her safety might have been compromised on a visit to Feltham. I trust that the family did not feel vulnerable when they visited Feltham and that the report provides some reassurance that their safety was considered by staff.

207. In respect of his own safety, he was involved in a number of altercations at Feltham. Naming a prisoner on an SIR suggests that the incident was considered to be important and was relevant to his safety, as well as prison security.

208. There is no doubt that he came to the attention of staff on many occasions. He did not report any of the altercations with other prisoners as a reason to think about harming himself. Nor did he tell staff that he had any suicidal thoughts. Certainly staff commented that he appeared confident living at Feltham. I have already recommended that consideration should have been given to using the violent reduction policies and so make no further comment about the incidents recorded on the SIRs.

## CONCLUSION

209. There has been much research about whether prison custody is the appropriate place for young people who offend. Her Majesty's Inspector of Prisons reports that "most children and young people who end up in prison come from sadly predictable backgrounds". The prison estate is therefore dealing with some of the most challenging and vulnerable young people in society. Most of the man's stay at Feltham appeared to be a challenging period for him, as evidenced by the number of altercations he was involved in.
210. That he was sentenced to five years in prison just over a week before his death is worthy of note. Sadly, a common factor in prison suicides is that they occur soon after coming into custody. He may well have been in custody several times before but he had not been there as an adult or for a lengthy foreseeable period and so his experiences will have been different.
211. The support he was given in the community changed as well. He had good and well resourced relationships with his youth offending team workers although both relationships took sometime to develop. This level of intervention is difficult to continue within an adult prison setting.
212. Despite these risk factors, during his short stay at Portland, he showed no obvious risks to the staff and prisoners who he came into contact with. He spoke openly to reception staff about his concerns regarding the distance between Portland and his family. This appeared to have been relieved by the reception officer's conversation with his mother. He socialised with other prisoners, including one who had helped him write letters before, and did not display any signs to them that he might harm himself. As well, from reviewing the telephone call to his family the day before he took his life, there is no suggestion that he intended to take his own life. Nevertheless, the note found in his cell clearly indicates that he did not wish to serve his sentence and continue living.
213. This investigation has been complex and included enquiries of a range of criminal justice agencies. Although I make no recommendations in this regard, it is worthy of note that so many staff who were interviewed had little recollection of their contact with him. I am sure that it will be a matter of regret to the Governors of the establishments and I am equally sure that it will provide little comfort to his family. Furthermore I am struck that, although well intentioned, much of the information which was intended to inform and reassure him was given to him in written form. He was a young man whose education was disrupted and limited and I find it hard to believe that information leaflets would have relieved his anxieties.

## RECOMMENDATIONS

1. The Governor at Feltham should remind staff that risks identified when completing cell sharing risk assessments should be followed up by the violence reduction measures and security incident reports.

**The Prison Service has accepted this recommendation.**

2. The Governor at Feltham should remind staff of the importance of completing ICA2 documentation to ensure that each young prisoner has the opportunity to voice any concerns about the transfer.

**The Prison Service has accepted this recommendation.**