

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of man  
in August 2013, while a prisoner at HMP Portland**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man at Dorchester County Hospital, on 13 August 2013. The man had been found hanging in his cell at HMP Portland five days earlier and had suffered a very severe brain injury because of loss of oxygen. He was 33 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care and treatment the man received at the prison. Portland cooperated fully with this investigation.

The man had an extensive history of self-harm, usually by cutting, and had frequently been monitored under suicide and self-harm prevention procedures before he arrived at Portland in June 2013. This pattern continued and monitoring began again within a week of his arrival. Although he had harmed himself by cutting on 19 July, the next day a review assessed his risk of further harm to himself as low and he was no longer monitored. Monitoring began again after he harmed himself again a week later. There were further incidents of self-harm on 6 and 7 August, and the man told an officer that he would use a noose next time and barricade his cell. The next day, he destroyed property in his cell and was left to calm down but, shortly before 2.00pm, an officer found him hanging in his cell. He was taken to hospital, but did not recover from his injuries.

The investigation found that staff at Portland did not believe that monitoring the man was achieving much and they appear to have been going through the motions rather than trying to address the root causes of his distress. Assessments of the man's level of risk appear to have been too optimistic, leading to infrequent reviews, even after acts of self-harm. Similarly, the level of observations remained unchanged, even at times of heightened risk.

It can be difficult and frustrating for prison staff to have to deal with the seemingly intractable problem of someone who harms themselves repeatedly, sometimes in an attempt to get what they want, but there is a need to ensure that support measures remain focused on identifying and reducing risk. We cannot know whether it would have been possible to prevent the man's actions, but I am concerned that the suicide and self-harm prevention procedures were not used well to offer him the sustained and effective support that he needed. I am also concerned that officers did not follow the required procedures for notifying a medical emergency and, as a result, healthcare staff did not immediately bring the required emergency equipment and an ambulance was not called automatically.

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## SUMMARY

1. The man had a history of mental health problems, diagnosed as personality disorder, for which he was prescribed medication. He had a history of drug and alcohol abuse and was a prolific self-harmer. He had criminal convictions dating back to 1994.
2. On 20 March 2008, the man was remanded to HMP Gloucester, charged with robbery and actual bodily harm. On 17 March 2009, the man was convicted and given an indeterminate sentence for public protection. In June 2009, he transferred to HMP Dartmoor and then, in December 2012, to HMP Guys Marsh. Members of the mental health team, prison doctors, and the visiting psychiatrist at both Dartmoor and Guys Marsh assessed him and prescribed medication. The man often said that he had thoughts of harming himself and was supported and monitored under Prison Service suicide and self-harm prevention measures (known as ACCT) on 27 separate occasions.
3. The man transferred to HMP Portland on 22 June 2013. On 28 June, the man harmed himself by cutting his arms and ACCT procedures were started to help support him. Although he harmed himself again on 19 July, the ACCT was closed the next day. The man harmed himself six days later, and the ACCT was re-opened. The man continued to self-harm. On 7 August, he threatened that he would hang himself and barricade his door to prevent it being opened. On 8 August, he destroyed the property in his cell and was left in his cell to calm down. Throughout the period of ACCT monitoring, the level of observations remained the same at once an hour and was not raised at any time.
4. At 2.00pm on 8 August, an officer found the man hanging in his cell and called for emergency medical assistance. Officers and healthcare staff performed cardiopulmonary resuscitation (CPR) until paramedics arrived. A pulse was established, but the man remained unconscious and was taken by air ambulance to Dorchester County Hospital. He remained in intensive care at the hospital until he died on 13 August.
5. The investigation found that ACCT monitoring should not have ended on 20 July just a day after the man had harmed himself and he should not have been assessed as low risk at that time. One of the caremap actions for him to gain employment in the prison was marked as complete, although this had not been achieved and nothing had been done to address the underlying issue of boredom. We consider the level of observations should have been increased in response to incidents when he appeared to be at heightened risk and ACCT reviews should have been more frequent. We are also concerned that officers did not follow the required procedures for notifying a medical emergency so that healthcare staff attending did not immediately bring the required emergency equipment and an ambulance was not called automatically. We make two recommendations about these issues.

## THE INVESTIGATION PROCESS

6. On 14 August 2013, the investigator issued notices to staff and prisoners at Portland, informing them of the investigation and inviting anyone with relevant information to contact him. No-one responded.
7. The investigator visited Portland on 29 August and obtained copies of the man's prison and healthcare records. NHS England appointed a clinical reviewer to carry out a review of the man's clinical care. The investigator and the clinical reviewer interviewed eight members of staff on 25 and 26 September. The investigator gave initial written feedback to the Governor on 14 October.
8. The investigator informed the local Coroner of the investigation and the Coroner provided a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.
9. One of the Ombudsman's family liaison officers contacted the man's family to inform them about the investigation and to invite them to ask any questions or raise any concerns which they wished to investigation to consider. The man's family asked why he had been transferred to Portland, and about the way families are informed of a death in custody. The man's mother said that she had received two distressing phone calls from her son in which he said he had been raped at the prison.
10. The investigation has established that the man himself requested to transfer to Portland. The investigator listened to each of the 14 phone calls the man made to his family while he was at Portland the man did not mention an allegation of rape in any of these, there is no record that he raised this at the prison and no other evidence of this for the investigation to pursue. The man's family received copies of the draft report. There was one further question noted by the man's stepfather which does not impact on the factual accuracy of this report and has been addressed through separate correspondence

## **HMP & YOI PORTLAND**

11. HMP & YOI Portland was originally built in 1848 to hold convicted prisoners. It operated for many years as a borstal and then a youth custody centre. It became a young offender institution in 1989, holding young adult men between 18 and 21. In April 2011, it became a combined adult category C training and YOI young adult facility holding up to approximately 530 prisoners. NHS Dorset Community Healthcare Services are the healthcare provider at the prison.

## **HM Inspectorate of Prisons**

12. HM Inspectorate of Prisons conducted an unannounced follow-up inspection of Portland in April 2012. The Inspectorate found that there was a good focus on providing a positive and rehabilitative experience for prisoners. The inspection reported that the quality of ACCT suicide and self-harm monitoring documents was mixed and did not always reflect the individual care staff gave to support prisoners and that none of the six recommendations about suicide and self-harm procedures made at the previous inspection in 2009 had been fully achieved. There was no effective quality assurance system for ACCTs and too many staff had not had ACCT or mental health awareness training. Healthcare facilities were satisfactory and prisoners had access to doctors every week day and could see a doctor within 48 hours. There were also appropriate dental and specialist clinics and a mental health team.

## **Independent Monitoring Board**

13. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their most recent annual report for the period ending 31 March 2013, the IMB was concerned about the impact of the change of categorisation, which meant that nearly half the prison population were now adults over 21. The IMB believed that this increased the danger of bullying, debt and corruption.
14. The IMB reported that suicide and self-harm prevention procedures operated efficiently, although they noted that there had been a 50% increase in the number of incidents of self-harm from the previous year. The IMB considered that training in safer custody areas needed refreshing and that there was a decreasing pool of ACCT assessors. The IMB was also concerned about the large number of prisoners with serious mental health problems or personality disorders which increased the risks of suicide and self-harm.

## **Assessment Care in Custody and Teamwork (ACCT)**

15. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur.
16. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be

met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

### **Previous deaths at Portland**

17. There have been two previous deaths at Portland since the Ombudsman began investigating deaths in prisons in 2004: one in 2009 and the other in 2012. Both were self-inflicted but there were no significant similarities with the circumstances of the man's death.

## KEY EVENTS

18. The man was born in May 1980. He had a history of mental health problems, which were diagnosed as personality disorder, and a history of self-harm. He had criminal convictions dating back to 1994 and had been in prison several times before.
19. On 20 September 2008, the man was remanded into custody at HMP Gloucester charged with robbery and actual bodily harm. On 17 March 2009, the man was convicted and given an indeterminate sentence for public protection with a minimum period to serve of two years before he could be considered for release. (After that, the Parole Board can direct release if it is satisfied that the prisoner no longer poses a risk of re-offending.) The man transferred to HMP Dartmoor on 2 June 2009 and then to HMP Guys Marsh on 20 December 2012.
20. During his time at Dartmoor and Guys Marsh, the man received extensive input from healthcare, the mental health team and the visiting psychiatrist. He was diagnosed as having a personality disorder. The man was prescribed anti-psychotic, anti-depressant and pain relief medication. Because of previous violent and racially aggravated offences, the man was assessed as a high risk to others and he was not allowed to share a cell with prisoners from minority ethnic backgrounds. On 24 May 2013, the man requested to transfer to HMP Portland, but he did not give a reason.
21. While the man was at Dartmoor and Guys Marsh, he had been monitored under ACCT procedures 27 times because of his risk of self-harm. The last ACCT at Guys Marsh was opened on 11 June, when the man threatened to harm himself as he had not received some money sent into him and he had been unable to buy tobacco. The ACCT was closed on 17 June. The man described his self-harming behaviour as being a release and also as being a way to get what he wanted. He usually self-harmed by cutting himself on his arms and legs and sometimes his face. He used razor blades or sharp objects (such as screws or shards of broken furniture or cell equipment). If he thought he might be removed from his cell and put into segregation, he secreted blades in his mouth or rectum for later use. Sometimes, he swallowed razor blades but usually declined to attend hospital for investigation or treatment.
22. On 22 June, the man transferred to Portland. When he arrived a mental health nurse recorded that the man was prescribed quetiapine (which is often prescribed for people with borderline personality disorders to help reduce impulsive behaviour), nefopam (for moderate pain), gabapentin (for neuropathic pain) and trazadone (for insomnia). He was given his medication daily. Although the man had requested the move to Portland, he told the mental health nurse that he would ensure that he got moved to the segregation unit so that he could transfer to another prison. The mental health nurse noted that the man was very agitated and told him that someone would see him the next day. An officer saw the man in reception and allocated him to a cell on the induction wing.
23. The next morning, the mental health nurse and another nurse, went to see the man. The mental health nurse recorded that the man was truculent, hostile and continually raised his voice. The man made threats towards the doctor if his

medication was changed. The mental health nurse discussed with the man the support they could offer, such as therapy sessions, but the man said he was not interested.

24. The same day, an officer recorded in the man's record that he had initially spoken to staff sensibly and respectfully, but his demeanour had changed during the course of the day. The man became abusive to staff and threatened to smash up his cell and assault the doctor if he was not prescribed the medication he wanted. The officer later noted that the man had apologised to him and said that the staff at Portland had treated him with respect and professionalism. Because of the man's threats, it was decided that a prison officer should be present at healthcare appointments.
25. On 24 June, a prison doctor saw the man and a Supervisory Officer (SO) was also present. The doctor recorded that he saw no reason why the man was prescribed trazodone (used to treat depression and anxiety.) The man accepted this and agreed that he did not need it. The man asked the doctor if he could be prescribed pregabalin (for muscle pain) instead of gabapentin. The doctor decided to prescribe a 75mg dose of pregabalin, stop the gabapentin and reduce the trazodone to alternate nights. The man told the doctor that he would engage with the mental health team. The doctor recorded that the man was to be seen a week later.
26. On 25 June, the officer recorded in the man's prison record that his moods had been very unpredictable throughout the day. In the morning, he had been polite and compliant but in the afternoon he had threatened to smash his cell and television and said he would not take his medication. By the evening he was calm, had taken his medication and had not damaged his cell or its contents.
27. On 27 June, the man moved from the induction wing to Nelson wing which held a mix of adult prisoners and young adults under 21. The residential officer on Nelson wing, explained to the investigator that there were approximately 240 adult Category C prisoners in Portland but there was only one wing reserved just for adult prisoners over 21, which held 80 prisoners. The remaining 160 prisoners over 21 occupy cells on the other wings. Nelson Wing had about 30 prisoners over 21 living there out of a total of 75 prisoners.
28. On 28 June, the man harmed himself by making two lacerations to his left forearm. An officer immediately opened an ACCT document at 1.45pm. A nurse saw the man in his cell and cleaned and dressed the wounds. An officer completed an ACCT assessment interview with the man at 4.15pm that afternoon. He recorded that it was difficult to get to the bottom of the man's problems, but that he was an "angry individual who believe[d] that the world owed him a favour". The man said that he did not get the medication he thought he should have been prescribed, was not happy at Portland, his property had not arrived from Guys Marsh and he wanted a transfer closer to his family. The man said that he had self-harmed for years and would attempt suicide at some point although he could not say when.
29. A SO then chaired the first ACCT review meeting, which was also attended by an officer, the mental health nurse, another nurse and the man. The SO noted that the man was not happy that he was at Portland, and did not think that he

was getting the support he needed. The SO recorded that the meeting went around in circles, with no real conclusion.

30. The SO completed an ACCT caremap to support the man. The caremap documented that the man was to engage with the mental health team (an appointment had already been arranged for 17 July) and that he had been told how to access the Samaritans. The man was assessed as at raised risk of further self-harm. The level of observations was set at hourly throughout the day and night. Staff were required to document two meaningful conversations with the man during the core day, until the next ACCT review.
31. Another SO, the man and a member of the mental health team attended the next ACCT review on 1 July. The man said that he now felt fine and that he had self-harmed to relieve stress for years. He said he was keen to make a fresh start at Portland and was happy with his medication and that he had an appointment to see the mental health team. The man said he had no thoughts of self-harm or suicide. SO Shepherd told the man that his property had been found at Guys Marsh and that staff had requested that it should be sent as soon as possible. The man had also been given some paint. The ACCT caremap was reviewed and the level of observation was reduced to two observations during the night and two documented conversations during the day. A further review was to be conducted in seven days time. The man's level of risk of further self-harm was now assessed as low.
32. On 3 July, another prison doctor saw the man to review his medication, as arranged by the prison doctor. The man told the doctor that he would stop taking trazadone and nefopam if he could have an increase in pregabalin. The doctor recorded that, due to the wounds on his arms, the man was unable to use the gym at the time, which he had wanted to do. The doctor increased the dose of pregabalin to 100mg and stopped all other medication except quetiapine. His medication was still issued daily.
33. On 8 July, another SO chaired an ACCT review with the mental health nurse and the man. The man said that he was keen to work and was frustrated that nothing had been found for him. He said that his property had still not arrived from Guys Marsh. The ACCT caremap was reviewed. It is not clear whether an action to gain employment to alleviate boredom was added at this review, but it appears so. Although the action is not dated, the mental health nurse noted in the medical record that the SO had agreed to try and find some work for the man. The level of observation remained unchanged, with a further review to be held four days' later. The man's level of risk was still assessed as low.
34. Between 9 and 12 July, the man's prison records show that he was frequently spoken to about his bad behaviour and how this did not help him get a prison job. During this period, the man frequently threatened and swore at staff and threatened to smash his cell. On 9 July, an officer found the man packing his belongings. He said that he would barricade his cell once he had finished. The man threatened to try to escape over the wall and, as a result, was escorted around the prison at all times. He cut himself on 10 July but would not allow staff to dress the wounds and refused to see the mental health nurse on 11 July.

35. On 12 July, the SO chaired an ACCT review at which a SO, a nurse, three officers and the man were present. The man reiterated that he was keen to work and was frustrated that nothing had been found for him yet. The staff told the man that he would not be given a job until he could demonstrate that he could control his behaviour. The ACCT caremap was reviewed and the level of observation remained the same, with a further review to be conducted eight days' afterwards. His level of risk was still assessed as low.
36. On 15 July, the man asked the prison doctor for an increase in the dose of pregabalin as he thought that the pain made his mental health worse. (The man was prescribed pain relief for a number of ailments including pains in his arm, neck and "nerve pain".) The prison doctor increased the prescribed dose of pregabalin to 150mg.
37. On 16 July, the mental health nurse and another nurse saw the man for a mental health review. In preparation, the mental health nurse had reviewed the man's substantial history of interventions with mental health professionals at Dartmoor and Guys Marsh, including psychiatric reports. The man said that he had previously been diagnosed with paranoid schizophrenia. He said that he had completed many courses for emotional stability and was not convinced that therapy was helpful. The mental health nurse recorded that her observations of the man, since his arrival at Portland, were consistent with a person with personality disorder. The mental health nurse referred the man to be seen by the visiting psychiatrist.
38. When interviewed, the mental health nurse said that the man was adamant he had been diagnosed with paranoid schizophrenia. However she had not found any evidence of this whenever she saw him. The visiting psychiatrist visited Portland only one day a week, usually on a Thursday. As the man's referral was assessed as 'non-urgent' it could take up to six weeks before he had his appointment.
39. On 19 July, the man again harmed himself by cutting his right thigh. Healthcare staff cleaned and dressed the wounds. The next day, a SO, chaired an ACCT attended by a healthcare assistant and the man. The man said that he self-harmed the previous day out of boredom and frustration. He complained about his medication and the lack of care from doctors and the mental health team. The SO noted that the allocations team were trying to find him some suitable occupation to allow him more time out of his cell but that he would not be given a job until he was able to demonstrate that he could control his behaviour. The SO noted that the conclusion of the review was that monitoring the man under ACCT procedures was not serving any purpose, as it annoyed the man more than he felt supported. The SO recorded that the ACCT caremap actions had been completed, although the man still did not have any employment which was one of the agreed targets. She closed the ACCT and set a post-closure review for 27 July.
40. On 26 July, the ACCT was reopened after the man harmed himself. (It is not clear from the record when this happened or what form it took). Another SO chaired an ACCT review attended by the mental health nurse, an officer and the man. The man again complained about the lack of care he had received and demanded that his medication be changed. The mental health nurse noted in the medical record that the safer custody team had offered the man some

distraction tools, such as work and puzzle books, to help reduce the incidents of self-harm, but he had been insulted by this and thrown them out of the window. The mental health nurse noted that the man could not shower at the same time as others because of his cuts, and he was not allowed to go to activities with others because he had threatened to go on the roof. She added that it was difficult to offer him any form of distraction and that his way of coping was to harm himself every day. The SO added two actions to the caremap. The first was that the man should be seen by a member of the Offender Management Unit as soon as possible (the reason for this is unclear), and the second was for a protocol to be established setting out the man's daily routine. It is not clear if either of these actions was completed before his death. The man was told that the mental health team would continue to support him and that he would have an appointment with the visiting psychiatrist. The ACCT caremap was reviewed and the level of observation remained unchanged, with a further review in 14 days. His assessed risk was again recorded as low.

41. On 27 July, a nurse gave the man two 500mg soluble paracetamol tablets when he complained of having a headache. While waiting in the healthcare unit to be taken back to his cell, the man got into a fight with two other prisoners about race and religious issues. The man would not let a nurse examine him but she recorded that he had red marks on his forehead and cheeks.
42. On 29 July, an officer noted in the man's prison record that he had spoken to him over the previous two days about the incident in the healthcare unit. He recorded that the man's mood had been up and down and that the ACCT remained open due to his continued incidents of self-harm. As a result of the incident, the man had been kept on the wing and had been allowed to help the wing cleaners, which he was pleased about. Another officer noted that the man was working very well.
43. On 31 July, a nurse gave the man two 500mg soluble paracetamol tablets when he complained of a headache again. The next day, the man asked a nurse for some paracetamol when he collected his medication. The nurse noted that the man had requested paracetamol seven times since 11 July. She gave him two more soluble paracetamol tablets, but the man demanded more and asked to see a doctor. The nurse made an appointment for the man to see a doctor and sought immediate advice from the prison doctor. The prison doctor, did not see the man, but prescribed a total of eight 500mg soluble paracetamol tablets, two to be taken every four to six hours.
44. On 4 August, a nurse gave the man two more paracetamol tablets when he said he had a headache. That afternoon, a SO took the man to see his cousin, who was in another unit in the prison.
45. On 5 August another prison doctor saw the man as a result of the appointment the nurse had made for him. The man told the doctor that he experienced pain in his neck and that the pregabalin was helping but he suffered greater discomfort at night. The doctor prescribed an increase of the evening dose of pregabalin to 200mg, and 500mg paracetamol, two tablets of each to be taken four times a day. The doctor told the man that he needed to stay on this dose for some time so that the level of his pain relief could be properly assessed. The doctor also told the man that he was due to see the visiting psychiatrist.

46. During the night, the man spoke to an officer support grade and asked for a complaints form. When she took it to him, he said that it was a waste of time, and threatened to set fire to his cell and stand in the middle and burn. He then blocked his observation panel. The night orderly officer attended and spoke to the man for 30 minutes. He recorded that the man was very angry about his missing property which had still not arrived from Guys Marsh.
47. On 6 August, the man made two cuts to his left arm. The nurse cleaned and dressed the wounds. The man refused to attend an ACCT review with the SO, who assessed his risk as raised and increased the level of observations to hourly. The SO scheduled a review for the next day. For the rest of the day, the man continually pressed his cell bell and kicked the cell door. The SO recorded in the man's prison record that he had been spoken to about his behaviour, self-harm and his missing property but would not listen to reason, and blamed the staff for his predicament. The SO noted that he had explained to the man that it was his continual poor behaviour which impacted on what staff could do for him. The man was offered items to clean and dress his wounds a number of times but he refused.
48. Later that afternoon. The man had gone out on exercise but, at approximately 3.45pm, he refused to leave the exercise yard when officers ended the exercise period early. When he eventually came in, he told an officer that he had at least ten blades on him. (The records indicate that he was in his cell when he said this, but there is no record of whether anything was done about his claim to have the razor blades on him.)
49. At 6.34pm, the man telephoned his mother. During the call, which lasted just under two minutes, The man said that being at Portland was a joke. He complained about the regime, his sentence and said that he had no rights at all. The man's mother told him that he must be playing up and, with regard his sentence, said "you took a hammer to the bloke, you will never get out". In response, the man said "I don't need to hear this" and terminated the call. The man then tried to ring his mother again at 6.53pm, 6.57pm and 7.32pm but got no answer each time.
50. At the end of the evening association period, the man refused to return to his cell. He became agitated and said he had not had sufficient time to use the telephone. The man eventually went back to his cell after an officer pressed the general alarm bell, but he then smashed the glass observation panel in his cell door. The residential officer said that the man appeared to have a split personality as sometimes he was fine and polite to staff, then at other times he was agitated and lost his temper very easily. The officer charged the man with offences under Prison Rules for refusing to return to his cell and inciting others to do the same. The officer noted in the wing observation log that a lot of prisoners had pushed boundaries and that several behaviour warnings had been issued that day.
51. At 9.43am on 7 August, the man telephoned his mother. He apologised for the call the previous day and they spoke about how hot the weather was. His mother reassured him that she was not in a mood with him. The man said that he would write once he had received some stamps and would call again as soon as he could. At 10.00am, the man spoke to a physical education officer about his lack of access to the gym. At 11.00am, he rang his cell call bell. The

officer responded and found that the man had cut his arms. He told the officer that this was a coping mechanism, but that he had cut slightly deeper than usual. He also said that he had a noose and would hang himself if he did not get access to work and exercise. He threatened to build a barricade and said he would have used the noose before staff were able to get into his cell. The officer took the man to healthcare to get the cuts treated.

52. The SO went to the healthcare unit to speak to the man. He said that he would not hang himself but felt that he was not being listened to. A nurse dressed the man's wounds and recorded that he had threatened to hang himself. She also informed the mental health nurse.
53. The SO held an ACCT review that afternoon with a nurse and the man. The man agreed that he had had a very unsettled couple of days but felt he was not being listened to and was being mistreated by staff. The SO told the man that his property had now arrived from Guys Marsh (although he does not appear to have received it that day). His level of risk was assessed as raised and the level of observation was amended to three recorded conversations during the core day and hourly observations when he was locked in his cell. A further review was scheduled for 24 August.
54. A nurse told the investigator that she had known the man from his time at Guys Marsh. She said that the man liked interaction, whether positive or negative, enjoyed having an argument and would try and draw staff into it. The man would say things purely for effect, such as he was in danger from other prisoners, would say very dramatic things about harming himself and be in and out the segregation unit all the time. She described the man as having a very intimidating personal appearance in the way he dressed and his body language. The nurse said that the man got as much out of the negative interactions as he did out of the positive ones.
55. The nurse was aware that the man had threatened to hang himself earlier in the day, but said he had threatened this before several times at Guys Marsh. After the ACCT review, the SO told a nurse that it was likely that the man would be punished for breaching Prison Rules by smashing his observation panel and would most likely be sent to the segregation unit. When interviewed the nurse said that this had happened frequently at Guys Marsh because the man enjoyed the individual attention that prisoners receive when segregated from others. A nurse advised that the man's television should not be removed from his cell as part of a punishment as this would increase the risk of him self-harming. The nurse did not consider that the man gave any indication that he wanted to take his own life but she believed that the risk of him self-harming remained.
56. The SO saw the man when he returned from collecting his medication at 4.25pm. She recorded that the man was in a better mood and had handed in a razor blade without being asked.
57. That evening, an officer recorded in the wing observation book that it had been an "awful evening when it came to lock up". It had taken officers 25 minutes to get all prisoners into their cells and at one point they were not sure if they were going to achieve this. They issued a number of behaviour warnings to prisoner, but it does not seem that the man was involved.

58. At some point after 7.30am on the morning of 8 August, the residential officer noted in the wing observation book that a custodial manager had instructed that the man was to be searched every time he left the wing. The reasons for this were not clear from the records. That morning, the man became very agitated and pressed his cell bell four times. Officers responded and on each occasion the man had no specific request, but was argumentative and complained that his human rights were not being observed. At around noon, the man smashed his observation panel again and threw bits of broken cell furniture through the gap, onto the landing.
59. The residential officer said that, when a prisoner smashes up their cell at Portland, the policy is either to let the prisoner calm down or use a response team to remove the prisoner by force from the cell. A custodial manager and a SO decided to let the man calm down and move him later that afternoon to the segregation unit, under Prison Rule 45 – for the maintenance of good order or discipline. The residential officer said that the man was aware he was going to the segregation unit that afternoon in respect of disciplinary charges he was facing but he was not aware that they planned to relocate him to the unit. The custodial manager said that no decision about this had been made.
60. During the lunch period between 12.30pm to 1.30pm, the man pressed his cell bell twice. The officer answered the first bell. He recorded that at the time the man was shouting to a prisoner in the cell on the opposite side of the landing that he was being “stitched up”. The residential officer answered the second bell. The man was in a rage and had smashed his television and refused to talk to the residential officer.
61. In his statement to the police, the residential officer said that, at 1.40pm, he had begun unlocking prisoners to go to work. When he got to the man’s cell, he saw that he had bedding tied around his neck attached to the cell window. He appeared to be standing on the bed. The residential officer did not have a radio so he shouted for help and ran to get the custodial manager from the wing office. The custodial manager estimated that this was shortly before 2.00pm. They tried to open the cell door, but were unable to as the man had barricaded the door using the lockers in the cell.
62. An officer responded to the call for help and arrived at the cell. He radioed a code blue emergency (which indicates a prisoner is not breathing or is unconscious). The entry in the Communications Room Incident Log states that the officer radioed at 2.01pm. The log states ‘Healthcare required Nelson’. The next entry in the log was made at 2.05pm after another radio message from the officer saying ‘Defib required on Nelson’. An emergency ambulance was called at 2.05pm.
63. The residential officer ran to the wing officer to get an anti-barricade tool, which releases bolts that allows the cell door to be opened outwards on to the landing. However, there was no anti-barricade tool on Nelson wing so the residential officer had to go to Grenville wing, 70 metres away, to get one. He returned with the anti-barricade tool accompanied by two officers and opened the door. The custodial manager, and two officers climbed over the lockers which the residential officer then moved out of the way. They cut the man

down and placed him on the bed as there was broken glass and ceramics on the floor.

64. A nurse and two healthcare assistants arrived at the cell and started cardiopulmonary resuscitation. A doctor arrived shortly afterwards. An automated external defibrillator (AED - which monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary) was used but advised that there was no shockable rhythm. The resuscitation attempt continued until paramedics arrived at 2.20pm and took over the man's care, assisted by a doctor. The man was given two doses of adrenaline (to increase heart rate and blood pressure) in line with resuscitation guidelines and eventually a pulse was obtained. The man made some respiratory effort though he remained unconscious. The man was taken by air ambulance to Dorchester County Hospital. When he arrived at the hospital, the man was taken to the intensive treatment unit. It had been agreed that no restraints should be used, but that the man should be accompanied by two officers. The SO and officer travelled by car to the hospital to act as escort officers.
65. The prison contacted the man's mother, to inform her that her son was in intensive care and that his family could visit whenever they wished. The man's mother said that ill-health and the distance involved prevented her doing so, but asked to be kept updated by telephone.
66. The Governor debriefed the staff involved in the emergency incident. They discussed what had happened and were offered the services of the prison's care team. Officers and members of the chaplaincy were available to support prisoners affected by the incident. Prisoners subject to suicide and self-harm monitoring had their cases reviewed in case they had been adversely affected by the incident.
67. Healthcare staff at Portland remained in daily contact with Dorchester County Hospital. On 12 August, the hospital informed them that the man had suffered a catastrophic brain injury due to hypoxia (loss of oxygen) and had no prospect of recovery. The man was on the organ donor register and the hospital said that they would assess whether his organs were suitable for donation. If so he would have surgery, otherwise the life support would be withdrawn. The Governor decided that the escorting officers were no longer required.
68. An intelligence report was created on 12 August, from information given by the escort team. When the man had arrived at hospital, medical staff had removed a number of items from him including smoking material and a quantity of (non-specified) medication which they found hidden in his groin area. The writer of the intelligence report commented that this might suggest that the man had not intended to take his own life, but thought he would be removed from the cell and taken to the segregation unit.
69. On 13 August at 8.45am, a nurse contacted Dorchester County Hospital who informed her that the man's organs were not suitable for donation. Life support was withdrawn at 6.00am and the man died at 6.10am. The clinical reviewer noted that his sister was with him at the time.

70. Later that morning, Portland informed the man's mother that he had died, and in the days that followed maintained contact to offer support to his family. The prison contributed towards funeral expenses in line with national guidance.

## ISSUES

### Assessment of risk and ACCT procedures

71. The man had a diagnosed personality disorder, frequently self-harmed and had often declared thoughts of suicide while he was in custody. Between September 2008 and June 2013, the man had a total of 28 ACCT documents opened. The investigation has identified some concerns about the operation of ACCT procedures at the prison.
72. The man had regular multidisciplinary reviews at Portland and his level of risk was assessed at each review. However, we do not consider that his level of risk was always properly assessed or monitored. For example, the man cut himself on 19 July. Despite this very recent incident of self-harming behaviour, at a review the next day his risk of further self-harm was assessed as low without any clear indication to explain why it had reduced so quickly and without any evidence to suggest that anything had been done to address the underlying reasons. Despite the proximity of the self-harm, the SO decided that the ACCT could be closed as it was not serving any purpose. We believe that this decision was inappropriate given the very recent incidence of self-harm. ACCT monitoring should always continue when there is an identified risk of suicide or self-harm even, and perhaps especially, when it appears that little progress is being made.
73. On 26 July, the ACCT was re-opened after the man harmed himself again which is further evidence that the previous risk assessment was too optimistic. However, the ACCT review again concluded that the man's risk of suicide and self-harm was low. It is difficult to understand how this assessment was reached when there had been such a recent incidence of self-harm and in the light of his previous pattern of behaviour. These examples do not suggest that the case managers at Portland had the appropriate level of skill for assessing the risk of self-harm.
74. On 7 August, the day before his fatal incident of self-harm, the man cut himself, which was his usual method of self-harm. However, he told the officer who responded that he had a noose and would barricade his cell when he used it. A case review was held that afternoon, but we are concerned that there is no indication that this was discussed with the man and there is no mention of this in the note of the review. Despite the further incident of self-harm, the man's suggestion that he would hang himself, and the case manager noting that he had been very unsettled for a couple of days, the level of observations while the man was in his cell remained at hourly. We consider that these factors should have led to an increased level of observations. We do not believe that hourly checks are sufficient to support a prisoner with a record of self-harm who has made a very recent threat to hang himself.
75. On 8 August, the man destroyed property in his cell. The manager of the prison at the time, the custodial manager, decided that the man should remain in his cell until the afternoon when he would be moved to the segregation unit. He was not informed of this plan, but it is possible that he anticipated such a move. There is no evidence that any consideration was given to increasing the level of observations in response to this incident, even though the damage to

the cell gave The man further opportunities to harm himself. Nor was there any consideration that his destructive behaviour might be an indication of increased frustration and thus heightened risk.

76. When the ACCT was re-opened on 26 July, after the man had harmed himself again, the next case review was set for 14 days. Before that review was held, the man harmed himself again on 7 August and another review was held that day. Although the man had also made specific threats that he would harm himself again, the next review was again set for 14 days later. We believe that reviews set at 14 day intervals for someone who is actively self-harming demonstrates that there was insufficient focus on seeking to reduce The man's risk.
77. The man said that he harmed himself because he was bored. The need for occupation was one of the issues listed on the caremap when the ACCT was opened on 28 June as needing to be addressed. We are concerned that the caremap action for the man to gain employment was marked as complete when the ACCT was closed on 20 July although the man had not yet got a prison job. Much of the responsibility was placed on him. Prison Service guidance stipulates that ACCTs should not be closed until all caremap actions have been completed. There is little evidence that active steps were taken to help the man get occupation which would have helped take his mind off self-harming behaviour. For most of the time he seems to have been locked in his cell without an adequate regime – which is not healthy, even for someone who is not regarded as a risk of suicide and self-harm. It is important that caremap actions actually address the issues identified in the assessment and that ACCTs are not closed before this happens.
78. Overall, we consider that the operation of the ACCT procedures at Portland did not give the man sufficient active support or help manage and reduce his level of risk of suicide and self-harm. We accept that the man could be difficult to manage and had been monitored under ACCT procedures many times during his sentence without any great success. However, during the final period of ACCT monitoring it is hard to avoid the conclusion that ACCT procedures were followed because they were mandatory, rather than because anyone thought that the process might help support the man or reduce his risk. The SO explicitly recognised this when she closed the ACCT.
79. We believe that there is a need to review the operation of ACCT procedures at Portland and make the following recommendation:

**The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:**

- **Assessing the level of risk and recording the reasons for decisions;**
- **Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;**
- **Completing ACCT documents fully and accurately so that all incidents of self-harm and suicidal ideation are discussed and recorded at reviews with caremaps revised and updated;**
- **Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.**

## **Clinical care**

80. The clinical reviewer examined the standard of healthcare the man received at Portland and her report is annexed to this report. The clinical reviewer made two recommendations about physical health checks for prisoners taking antipsychotic medication and annual medication reviews of prisoners prescribed pregabalin and gabapentin as these drugs are often misused in prisons. As neither of these issues were related to the cause of the man's death we do not repeat the recommendations in this report, but the Head of Healthcare at Portland will need to consider them.
81. The clinical reviewer noted that the man was a very challenging prisoner to care for but concluded that the care he received was equivalent to that he could have expected to have received in the community.
82. The man was diagnosed by psychiatrists as having a personality disorder and was prescribed medication although, in general, personality disorders are not usually considered to be medically treatable. The prescribed medication was a variety of modest dose antipsychotics to help stabilise his mood. The clinical reviewer noted that the man might at times have suffered from low mood and depression rather than merely just being fed up with his situation. He had been prescribed antidepressant medication at times throughout his time in prison. The clinical reviewer commented that the man was otherwise medically fit, although he had been infected with Hepatitis C in the past.
83. The clinical reviewer considered that it was appropriate for the primary mental healthcare team to manage the man as there was no evidence of a psychotic illness. The clinical reviewer believed that it was appropriate that the man's medication should be reviewed by the visiting psychiatrist. Although the visiting psychiatrist had not seen the man by the time he died, there was nothing to suggest that a more urgent referral was required and the clinical reviewer noted that the timescale of four to six weeks was comparable with that in the community for a similar review.
84. The man frequently harmed himself and described this behaviour as a coping mechanism and a way to get what he wanted. Healthcare staff recognised that it was not possible to stop the man's self-harming behaviour, but strategies were devised to try to manage and reduce the occurrences and the severity of this behaviour, sadly without effect. The man had undertaken behaviour management courses in previous prisons and was offered distraction tools at Portland. In general, the clinical reviewer was satisfied that the man received a good standard of care from prison healthcare staff and was able to access services, including mental healthcare appropriately. She found evidence of good communication between the mental health staff and between healthcare and prison staff.

## **Emergency response**

85. The custodial manager said that the residential officer came to the wing office shortly before 2.00pm and reported that the man was hanging in his cell. The officer radioed a code blue emergency at 2.01pm, but an ambulance was not called until 2.05pm. The officers were unable to get into the man's cell quickly

as there was no anti-barricade tool on Nelson wing. After the man's death, the Governor issued an instruction that each wing should have an anti-barricade tool kept in the same place on each wing. As this issue has been addressed, we do not make a recommendation.

86. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes provides guidance to staff on communicating the nature of a medical emergency and ensuring there are no delays in calling ambulances. Paragraph 5.4 says:

*“A representative NHS Ambulance guide for use in the community states that an ambulance should be called when there are signs of chest pain, difficulty in breathing, unconsciousness, severe loss of blood, severe burns or scalds, choking, fitting or concussion, severe allergic reactions or a suspected stroke. This must also be the case for prisoners and therefore, in these situations when the emergency is called over the radio network an ambulance must be called immediately.”*

87. PSI 03/2013 was issued on 1 February 2013 and required all governors to have a medical emergency response code protocol based on the instruction by 28 February 2013. Portland has been unable to supply us with such a protocol and it is apparent from the response to this emergency incident that there was a lack of clarity about what should happen and an ambulance was not called immediately the code blue was issued. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Portland has a Medical Emergency Response Code protocol which:**

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment;**  
**and**
- **Ensures there are no delays in calling, directing or discharging ambulances**

## RECOMMENDATIONS

1. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - Assessing the level of risk and recording the reasons for decisions;
  - Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;
  - Completing ACCT documents fully and accurately so that all incidents of self-harm and suicidal ideation are discussed and recorded at reviews with caremaps revised and updated;
  - Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.
  
2. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Portland has a Medical Emergency Response Code protocol which:
  - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
  - Ensures staff called to the scene bring the relevant equipment; and
  - Ensures there are no delays in calling, directing or discharging ambulances

## ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p>The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <p>a) Assessing the level of risk and recording the reasons for decisions;</p> <p>b) Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;</p> <p>c) Completing ACCT documents fully and accurately so that all incidents of self-harm and suicidal ideation are discussed and recorded at reviews with caremaps revised and updated;</p>	<p>Accepted</p> <p>Accepted</p> <p>Accepted</p> <p>Accepted</p>	<p>A Local Governors Notice to Staff will be issued for the information of all staff and the guidelines surrounding the management of ACCT documents will be reinforced during ACCT training and refresher training</p>	<p>March 2014</p>	

	d) Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.	Accepted			
2	<p>The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Portland has a Medical Emergency Response Code protocol which:</p> <p>a) Provides guidance to staff on efficiently communicating the nature of a medical emergency;</p> <p>b) Ensures staff called to the scene bring the relevant equipment; and</p> <p>c) Ensures there are no delays in calling, directing or discharging ambulances.</p>	<p>Accepted</p> <p>Accepted</p> <p>Accepted</p> <p>Accepted</p>	<p>A Local protocol will be developed in line with PSI 03/2013 which details responsibilities during medical emergencies and that Portland has a medical emergency response code protocol.</p> <p>The Healthcare Department will give an assurance that relevant equipment will be available to respond to any given medical emergency that is called.</p>	March 2014	