

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP & YOI
Portland in October 2014**

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, who was found hanged in his cell at HMP Portland in October 2014. He was 22 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Portland was conducted. The prison co-operated fully with the investigation.

The man was troubled and had problems with drugs and alcohol. He had self-harmed from a young age and had spent time in psychiatric hospital and prison. He had been released from prison in December 2012, but was rearrested within days for further offences and recalled to prison. He arrived at Portland in March 2013, and worked hard to address his problems, which resulted in a marked decrease in his self-harming behaviour. He received support from the mental health team at Portland, but did not always take his medication as prescribed.

In February 2014, another prisoner attacked the man. The other prisoner was charged with criminal offences and the man was due to give evidence in court about the attack on 14 October. That day, he told staff that he had been so anxious about appearing in court that he had been thinking of harming himself. He handed them an improvised blade and a noose he had made. Staff arranged for him to give evidence by video-link and he said this had relieved his anxieties and he no longer felt like harming himself. Staff therefore did not consider it necessary to manage him under Prison Service suicide and self-harm prevention procedures, but did not formally assess him after he gave evidence. He appeared to settle and no one had any concerns about him. Sadly, one morning towards the end of October, a night patrol officer found him hanged in his cell

Overall, I am satisfied that the man received a good standard of pastoral and mental health care at Portland, in many respects, better than he might have received in the community. He had a long history of self-harm, which indicated that there was always an underlying risk, but, at the time of his death, there was little to indicate that he was at particularly heightened risk of suicide. I consider that it would have been difficult for staff to have predicted his actions or prevented his death. However, the investigation identified some areas for improvement, including the need for better assessment, recording and information sharing about prisoners at risk. Portland's emergency procedures did not comply with national guidelines, which meant the prison did not call an ambulance immediately he was found. Although the delay did not make any difference in his case, in other cases this could be crucial and is a matter I have raised with the prison before.

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.

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SUMMARY

1. The man had a history of drug and alcohol use, and had spent time detained in prison and in hospital for psychiatric treatment. He had a long history of self-harm and had previously attempted suicide and had been managed under Prison Service suicide and self-harm procedures (known as ACCT) many times. In December 2012, he was released from prison but a few days later was arrested and recalled to prison. In March 2013, he arrived at Portland. He was under the care of the mental health team, but did not always take his medication as prescribed. He worked as a cleaner in the prison's first night unit, where he was a permanent resident, and settled well.
2. In February 2014, another prisoner attacked the man and the police charged him with assault. In June, he told staff that he had taken an overdose, and they managed him under ACCT procedures. In August, he disengaged with the mental health team for a while. In September, his aunt died and the prison allowed him to attend her funeral. Shortly afterwards he spent a day out of the prison to receive a mental health award for the progress he had made.
3. On 14 October, he was due to give evidence in court about the assault. He was very anxious and said he did not want to go. The unit manager arranged for the man to give evidence by video-link, which he was relieved about. He handed staff an improvised weapon and noose and said he no longer intended to harm himself. Staff discussed whether to begin ACCT procedures but agreed that they would wait until after he had given evidence by video-link. After giving evidence, he seemed his normal self and staff were not concerned about him. However, he had no formal assessment.
4. The man did not always take his medication in October. On 23 October, he did not appear to have any particular problems. He played pool and mixed well with other prisoners during his free time. After he was locked up for the night, he saw a Listener (a prisoner trained by the Samaritans to offer support to other prisoners), but this was not unusual. The Listener spent about 45 minutes with him, who gave no indication that he intended to harm himself.
5. Just before 6.00am, a night patrol officer checking prisoners found the man hanging by a torn sheet. He radioed for help but did not use an emergency code and there was a slight delay before the prison called an ambulance. The night patrol officer went into the cell immediately and cut the sheet from his neck. Other staff arrived, but it was evident that he had died and they did not attempt resuscitation.
6. Despite the man's history of self-harm, at the time of death there was little to indicate that he was at raised risk of suicide and it would have been difficult for staff to have predicted his actions or prevented his death. He received good support from the staff at Portland but they did not always record important information about his risk, as they should have done and did not formally assess him after his video-link court appearance on 14 October. Emergency procedures also need improvement. We make three recommendations.

THE INVESTIGATION PROCESS

7. 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.
8. The investigator went to Portland on 29 October 2014, saw where the man had lived and spoke to prisoners who had known him. He obtained copies of his prison record, recordings of his telephone calls, and recordings of staff radio traffic on the morning of 24 October. He interviewed members of staff and prisoners at Portland in October 2014 and January 2015.
9. NHS England, South Central Area Team, commissioned a clinical reviewer to review the man's clinical care at the prison. The investigator discussed the review with the clinical reviewer during the investigation.
10. We informed HM Coroner for Bournemouth and Poole Eastern District of the investigation, who provided the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted the man's father to explain the investigation and invite him to identify issues he and his family would like the investigation to consider. He said that his son had a history of self-harm and asked whether support had been reduced because he had not harmed himself for a while. He also asked whether his son was prescribed medication and whether there were any indications that he was taking any illicit drugs. The family received a copy of the draft report. They did not make any comments.

HMP & YOI PORTLAND

12. HMP & YOI Portland holds up to 530 men, including young adults between 18 and 21. NHS Dorset Community Healthcare Services are the healthcare providers. There are no nurses on duty at the prison overnight.

Her Majesty's Inspectorate of Prisons' report

13. HM Inspectorate of Prisons most recently inspected Portland in July 2014. Inspectors reported that resettlement arrangements were limited. The care and case management of those at risk of suicide and self-harm were inconsistent, particularly on larger wings. Where staff had more time, such as on the Collingwood Unit, good care was more evident. Inspectors were not assured that recommendations from previous Prisons and Probation Ombudsman's investigations into deaths at Portland had been properly implemented. Primary mental health services were affected by staff shortages at the time, but inspectors noted that secondary mental health services were very good.

Independent Monitoring Board (IMB) report

14. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In their annual report for the year to 31 March 2014, the IMB were concerned about the management of prisoners who habitually self-harmed. They considered that resettlement arrangements were not always effective.

Previous deaths at Portland

15. Three prisoners have taken their own lives at Portland since the Ombudsman began investigating deaths in prisons in 2004, the most recent in August 2013. We have previously recommended that the Governor improve emergency response procedures.

Assessment, Care in Custody and Teamwork (ACCT)

16. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take 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. 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. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

17. The man had a number of convictions and had been in prison before, including Portland. He had a history of alcohol and drug misuse and had been admitted to hospital several times for mental health problems. He said he had harmed himself since the age of 12, as a way of coping with stress. His medical record noted that he had overdosed on medication, tried to strangle and hang himself and had deliberately cut himself in the past. He had harmed himself in and out of custody and prison staff had used Prison Service suicide and self-harm prevention procedures (ACCT) to manage his safety a number of times. In 2011, he was sentenced to three and a half years in prison. He was released from prison on licence in December 2012.
18. Within days, the man was arrested for further offences, including making threats to kill. His licence was revoked and he was sent to HMP & YOI Reading. He had a comprehensive mental health assessment and was referred to a psychiatrist, who prescribed olanzapine as a mood stabiliser. He did not settle well at Reading. On 6 January 2013, he cut his arm, and staff opened an ACCT plan. On 21 January, he cut his arm again. On 23 January, he smashed the observation panel in his cell and used the broken glass to cut his arm once more. He said that he had been trying to contact someone from the mental health team but had been unable to do so.
19. Reports showed that the man tried hard to work with staff to improve his behaviour in prison, but this was interspersed with incidences of challenging behaviour. On 27 March, he assaulted a prison officer. (He was subsequently convicted of this and sentenced to a further four weeks imprisonment.) On 29 March, he transferred to Portland.
20. Portland staff knew the man as he had previously been there. Although he was still being managed under ACCT procedures, he told induction staff that he had no thoughts of harming himself and was pleased to be at Portland. On 12 April, staff ended ACCT monitoring. At the end of April, staff found him with medication that was not his and began ACCT procedures again. Over the following weeks, he cut his arms twice.
21. At the end of April, the man took an overdose of paracetamol and ibuprofen. Staff continued to manage him under ACCT procedures, but the following month he took another overdose: this time of sertraline, an antidepressant that had not been prescribed to him. The prison psychiatrist assessed him, diagnosed depression and prescribed mirtazepine and a higher dose of olanzapine. Later that month, he harmed himself again by cutting his arm, and needed hospital treatment.
22. On 5 June, the man was convicted of making threats to kill and sentenced to 40 months imprisonment. He had been very anxious about appearing in court, but said that he was relieved and pleased with the outcome. He remained under the care of the mental health team and staff closely monitored him over the following days. On 20 June, he saw a psychologist and began a treatment plan to help him develop skills to cope with emotional disturbances.
23. On 24 June, the man moved to Collingwood Unit, the prison's induction unit, to work as a painter and live there. He began an 'Insider Recovery' course (to

help people with mental health problems) and said he felt that he was benefitting from it. Staff closed his ACCT plan on 4 July, after staff noted a dramatic improvement in his behaviour. He began working as a cleaner, and enjoyed being one of the permanent prisoners on the induction unit, with the responsibility that came with that. His relationship with his parents was sometimes difficult. In October, after a particularly distressing phone call with them, staff began ACCT procedures, but ended them two days later.

24. The man made efforts to progress. He applied to become a Listener (prisoners trained by the Samaritans to support other prisoners), was baptised and took a peer mentor course. He worked on Collingwood Unit as an Insider (a prisoner who helps new prisoners settle at the prison) and as an Equalities Representative. Staff reported that he flourished in these roles.
25. At the end of January 2014, the man said that he wanted to reduce his daily dose of mirtazapine, to prove that he did not need it. He began to miss doses, which caused fluctuations in his mood. In early February, he began to take his medication again. He said that he felt more settled, but on 3 February, staff were concerned at his low mood. In view of his history of self-harm, they started ACCT monitoring. This was closed two days later.
26. On 25 February, another prisoner seriously assaulted the man in an apparently unprovoked attack, fracturing his eye socket, dislocating his jaw and knocking out a tooth. Police charged the alleged attacker with assault. After this, he was anxious about moving around the prison without a member of staff. On 27 February, the psychologist saw him and thought that, emotionally, he was recovering well from the assault.
27. On 10 April, the man chose not to go to an appointment with the psychologist. A mental health nurse went to see him, who said that he no longer wanted to see anyone from the mental health team, because he thought that he was doing well. The psychologist noted in the medical record that he would work with him again if he chose to re-engage.
28. On 17 April, the psychologist went to see the man to check that he still did not want any support from the mental health team. He said that he was enrolled on a number of training courses and was happy on Collingwood Unit. He said that he had not harmed himself for nearly a year, had not been taking any medication for two weeks and did not need to see anyone. The psychologist told him that, if he felt his mental health beginning to deteriorate, he should contact the mental health team straight away. The psychologist asked prison officers to contact the team if they had any concerns about the man.
29. Officers on the unit continued to praise the man for his positive attitude to his work and the support he gave to other more vulnerable prisoners. However, his mood fluctuated. On 24 May, he started taking his medication again and this stabilised his mood. He said that the assault had made him anxious about collecting his medication from the healthcare centre, so officers tried to ensure that someone accompanied him. (This was an informal arrangement, which continued until he died.)
30. The man had applied to be re-categorised to security category D to enable him to move to an open prison. At the end of May, he learned that his application

had been unsuccessful. Although he was disappointed, staff reported that he accepted the decision. He enrolled on a mental health awareness course and began to use the gym.

31. On 4 June, the man told a prison GP that he had blacked out a number of times over the previous two weeks and was feeling lethargic and tired. The doctor could not find anything wrong, and suspected it might have been caused by tension. He asked him to keep a record of any further concerns.
32. The man had applied for release on temporary licence (when prisoners are allowed out of prison for a short period) to help him prepare for his release. However, in June, he learned that the rules on temporary release were to be changed, and he would no longer be eligible.
33. On 22 June, the man told a nurse and his personal officer that he had taken 48 paracetamol tablets two days before. The local Poisons Unit advised a nurse to send him to the accident and emergency unit at the local hospital for assessment. The nurse sent blood samples to the hospital. The results came back the next day and showed no paracetamol in his system.
34. Staff began ACCT procedures and the man said that he had taken an overdose because staff could not explain why he was not suitable for category D status and ineligible for release on temporary licence. He was upset that his parents could not visit him until August. He said that he had been unable to see a Listener in his cell, because he had been assessed as high risk for cell sharing, because of his offence. Staff assessed him as at raised risk of suicide and self-harm, and checked him once an hour. They referred him to the mental health team and noted that he should see his offender supervisor to discuss his eligibility for release on temporary licence. They noted that he should have access to Listeners and contact his mother.
35. On 25 June, the man had a mental health review during which he was agitated and disclosed negative thoughts. At 4.15pm that afternoon, staff noticed that he had hidden a blade and was trying to cut his arms. Officers restrained him and took the blade from him. At 6.10pm, he told staff that his mental health was deteriorating. Ten minutes later, he punched his pillow, and said that he needed to work off some frustration. He then banged his head against the cell door and tried to strangle himself with one of his socks. He barricaded his door and staff had to force entry. Officers restrained him and put him in anti-rip clothing under constant supervision (when the prisoner is watched at all times) in a cell with a gate, rather than a door. (Anti-rip clothing is made out of material which is extremely difficult to tear into strips to create ligatures.) At 7.05pm, he punched the wall hard, but refused any treatment. At 1.30am, on 26 June, officers saw him scratching his arm with a lolly stick, which he gave up when asked.
36. On 27 June, while still being constantly supervised, the man tried to hide his knife as he returned his lunch plate. Staff noticed and he handed it back. That afternoon, he agreed to go to hospital to have his hand examined after he punched the wall. An X-ray confirmed that he had broken his hand. It was set in a cast and he returned to prison.

37. On 30 June, the man attended a multidisciplinary ACCT review. The panel assessed his risk as raised and reduced the frequency of observations from constant supervision to one every hour.
38. On 2 July, the man told the psychologist that he had been very stressed the previous week and had decided to end his life. He said that, although the decision had comforted him at the time, he no longer had any thoughts of suicide or self-harm. He discussed what had triggered his suicidal thoughts and his reactions in a rational manner and the psychologist had no particular concerns about him. The psychologist recorded the appointment in his ACCT document.
39. On 15 July, the man had a positive telephone conference with his offender manager (probation officer). He had received papers to apply for home detention curfew (a scheme that allows prisoners serving short sentences to be released early on licence with an electronic tag to monitor their compliance with residence requirements). However, on 22 July, his offender supervisor told him that the papers had been issued in error and that he did not qualify for home detention curfew because of his offence. Although she had previously made notes in his ACCT document, she did not on this occasion.
40. Staff continued to manage the man under ACCT procedures. Prisoners assessed as high risk for sharing a cell were not usually allowed to have a Listener locked in their cell with them, but staff agreed that a particular Listener could go to his cell if he needed one.
41. On 24 July, staff reviewed the man's ACCT plan. All of the issues identified in the caremap had been resolved; he was taking his medication regularly and was in good spirits. All present agreed that the ACCT could be closed.
42. That day, the man did not attend an appointment with the psychologist because he did not feel that he needed mental health support. On 14 August, the psychologist took him off the mental health team caseload, after he repeated that he did not need any mental health support and did not turn up to another appointment. On 18 August, he declined to attend a scheduled GP appointment, and did so again on 21 August. However, he continued to take his medication as prescribed.
43. On 5 September, the man heard that his aunt had died. The Listener went to his cell to support him and he used the Listener service again on 7 September. On 16 September, he was released on temporary licence for the day to attend his aunt's funeral. He told officers that he had re-established some family contacts and hoped that perhaps this might result in more family support when he left prison.
44. On 22 September, the man asked if he could see someone from the mental health team. A mental health worker was allocated his case and went to see him. He said that he was feeling down and asked if he could have a higher dose of olanzapine. He said he was having thoughts of self-harm, and was using distraction techniques to manage them. The mental health worker discussed him with officers on Collingwood Unit, who said that he had also told them how he was feeling. However, they agreed that they did not need to open an ACCT at that stage. That evening, he asked to see a Listener again, and

the Listener talked to him in his cell. He referred him to the doctor. On 24 September, a doctor increased his medication (although it is not clear if the doctor assessed him in person). He used the Listener service again on 30 September, 1 October and 4 October.

45. Staff in the healthcare department had nominated the man for a community award in the Road to Wellness scheme (for people who have made significant progress in their own mental health recovery or supporting the recovery of others), which he won. On 7 October, he did not collect his medication. That afternoon, he was released on temporary licence and went to the award ceremony with his personal officer. That evening he spoke to a Listener.
46. On the morning of 8 October, the man telephoned his offender manager and asked about the possibility of being released again on temporary licence to help him plan his resettlement. She told him to speak to his offender supervisor about this. He said that he had fallen out with his parents and wanted to move away from Hampshire, when he was released. He told her that he would see her at a meeting they had scheduled in December.
47. At 4.49pm on 8 October, the man telephoned his parents. They argued and he ended the conversation by saying that they would not hear from him again.
48. The man saw a Listener on 10, 11 and 12 of October. On 13 October he did not collect his medication. That evening, he asked to see a Listener. He was due to give evidence at court the next day about the assault on him in February, and was worried about this. The night patrol officer spoke to him, who said he would not go to court the next day, but would not harm himself.
49. On the morning of 14 October, the man went to the staff office and said he was not going to court. He had an improvised blade in his hand. An officer, who worked in the safer custody department and was in the unit office at the time, told the investigator that he appeared to be in control, but angry. She said that he was not threatening to harm staff or himself with the weapon, but was just holding it and saying that he was not going to court. At this point a custodial manager came into the unit and asked him to come to his office to discuss the problem.
50. The man told the custodial manager that he did not want to go to court and the custodial manager suggested that it might be possible for him to give evidence by video-link. He agreed to consider this. He left the weapon in the office and went back to his cell. The court agreed that he could give evidence by video-link and prison staff arranged this.
51. An officer went to the man's cell to see if he was okay. He told her that he felt a bit better about giving evidence by video-link and handed her a length of torn bed sheet that he had tied into a noose. He said that he had made it the previous evening and had been thinking of using it but had no intention of doing so now the situation about going to court had been resolved. She took the noose to the office and showed other staff, including a custodial manager, who went to speak to him. He said he had made the noose to stop staff from taking him to court. He said that he had no intention of harming himself, but had been stressed because of his recent problems with his parents, the loss of his aunt and the court case.

52. The mental health worker went back to the office and staff discussed whether they ought to support the man under ACCT procedures. He said that the man was usually open about his self-harm, and he believed him when he said he now did not intend to harm himself that morning. The officer told the investigator that a custodial manager suggested that they should consider opening an ACCT if he was still upset after he had given evidence by video-link. (When interviewed, the custodial manager said he did not remember this discussion.) None of these events or decisions were recorded in the man's prison record or the unit observation book. The mental health worker made a routine referral (which would usually take between two to three weeks) for the man to see a mental health nurse to assess whether he needed to see a psychologist for additional support, because of his recent stresses.
53. An officer took the man to the prison's video-link facility. She told the investigator that, once he had given his evidence, he was visibly relieved. (Anecdotal evidence from prison staff suggested that he told the court that he did not know who had attacked him and the case was dismissed.) Staff on Collingwood Unit said that when he got back from giving evidence, he was relieved and calm, and they had no further concerns about him. No one discussed his video-link appearance in court with him or formally assessed his risk of suicide and self-harm, after he had given evidence.
54. On 15 October, the man saw a Listener. On 16 October, he saw a doctor about a lump in his groin. The doctor examined him and found no other symptoms, but sent samples for testing. (He did not attend an appointment on 23 October, to discuss the findings of the tests, which did not indicate any significant concerns.)
55. The man did not collect his medication on 17, 18 and 19 October. He told an officer that he disliked taking it, because it made him feel "not like himself" and that he might come across the prisoner who had attacked him, when going to the healthcare centre to get it. He was also worried that other prisoners would make assumptions about him. The officer spoke to healthcare staff to ensure that they knew that he was not taking his medication. Healthcare staff at Portland had a policy of following up any prisoner who did not collect his mental health medication for three days. However, he collected his medication on 20 and 21 October, so no one went to see him about this.
56. On 21 October, the man's offender supervisor went to see him to tell him she would be away for a week, and to see if he needed anything before she went. He was due to be released in February and would initially live in a hostel. They talked about how he could see his family when he was living there and discussed possible employment options. She did not have any concerns about him after their conversation. The next day, 22 October, he did not collect his medication.

Events leading up to the incident

57. At 8.16am on 23 October, the man telephoned his grandmother. He told her that he had not spoken to his father for over two weeks and did not intend to. He said that, when he was released from prison, he planned to move somewhere new.

58. Later that morning, an officer took the man to reception where he worked as part of his Insider duties. On the way, he said he was in a funny mood and had not slept well. She encouraged him to take his medication, but he said that he did not like it. Records show that he did not collect his medication on 23 October.
59. Two new prisoners the man saw in reception that day told the investigator that he seemed calm and relaxed when they met him. They both saw him again that evening in Collingwood Unit. Neither of them spoke to him, but both said that he seemed happy and was playing pool with other prisoners. One of the other permanent residents of Collingwood Unit said that the man usually took his medication after dinner, and then had a lie down. However, that evening, he stayed out of his cell, playing pool and mixing with other prisoners. The prisoner said that he seemed to be happy. An officer said that she noticed him talking to other prisoners and had no apparent problems.
60. At 6.23pm, the man phoned his cousin. There was nothing in the telephone call to suggest that he was distressed, and he finished the call by telling her that he would phone again the next day.
61. Prisoners were locked in their cells at approximately 7.15pm. Shortly afterwards, the man rang his cell bell and asked to see a Listener, which was not unusual – he had requested a Listener ten times in the previous month. An officer brought a Listener to his cell. The Listener said that he often saw him in his capacity as a Listener. He said that sometimes he was upset, sometimes feeling low and sometimes he just wanted to talk. The content of conversations between prisoners and Listeners is confidential, but he told the investigator that the man gave no indication that he was thinking of harming himself.
62. The Listener spent about 45 minutes with the man. Part of the man's unit responsibilities included laundry, and as they parted he asked the Listener to have his laundry ready for him to collect the next morning. When an officer came to take the Listener back to his cell, the man said that he would see her in the morning. Neither the officer nor the Listener thought that he seemed particularly stressed or upset.
63. The night patrol officer patrolled the wing about three times during the night. He said that no prisoners pressed their cell bells that night. (The electronic system to record cell bells was not working so we have been unable to verify this.) There were no entries in the wing observation book about the man during the night.
64. The man's cell was between the permanent prisoner's and one shared by the two new prisoners. One of the new prisoners said that after being locked in his cell, he did not hear anything from the man's cell all night. The other new prisoner said that he had trouble sleeping, and was awake until about 3.00am. He said that, at some point in the night, he heard some banging about, but thought nothing of it. He did not hear the man's cell bell through the night. The permanent prisoner said that he did not hear anything from the man's cell during the night.

65. The night patrol officer began a morning roll check at approximately 5.45am. When he got to the man's cell at about 5.50am, he looked through the observation panel and saw that the bed had not been slept in. He then saw him hanging from the cell window with a torn piece of sheet around his neck and radioed immediately for urgent assistance.
66. The night orderly officer in charge of the operation of the prison that night responded that she was on her way. She and the rest of the night staff ran to Collingwood Unit. Portland does not have healthcare staff on duty at night.
67. Apart from the night orderly officer, night staff do not carry standard keys, but have a cell key in a sealed pouch for use in an emergency. As soon as he had radioed for help, the night patrol officer broke the seal and went into the cell. He used his anti-ligature knife to cut the sheet from the man's neck. He could find no pulse on his neck and wrist. He was cold and the night patrol officer thought there were signs of rigor mortis. Other staff then arrived.
68. The night orderly officer reached the cell first and, when she got there, radioed the control room to call an ambulance, which they did at 5.55am. Staff in the control room told the ambulance service that the officers at the cell thought the man was already dead.
69. The night orderly officer and an officer checked the man for vital signs, but agreed that rigor mortis had set in. One officer was first aid trained and asked if he should try to resuscitate him. The night orderly officer said that he was clearly dead and so resuscitation was not appropriate. The staff then left the cell and locked it until the paramedics arrived at 6.17am. At 6.29am, the paramedics confirmed that he had died. The ambulance service call-out log notes that rigor mortis was present and they did not attempt resuscitation.
70. The man had left a note in his cell, apologising for his actions and saying that could not deal with his problems. He had written a similar message in the back of his diary.

Contact with the man's family

71. The man had named his mother as his next of kin. The prison's family liaison officer, a prison chaplain and a prison manager arrived at the man's parents' home at 10.00am that morning and informed them of his death. The staff offered condolences and support. The prison offered a contribution to the funeral, in line with Prison Service guidance.

Support for prisoners and staff

72. The Governor chaired a debrief on the morning of 24 October for staff who had been involved in the emergency response and the staff care team offered support.
73. Staff reviewed prisoners being managed under ACCT procedures in case they had been adversely affected by the man's death. Extra support was provided on Collingwood Unit for prisoners who knew him.

Post-mortem

74. The post-mortem recorded the cause of death as hanging. There was no evidence of recent drug or alcohol use, only traces of his prescribed medication.

ISSUES

Recording decisions about risk of suicide and self-harm

75. The man had a history of self-harm, by various methods, from a young age. He had harmed himself both in and out of prison and had been managed under ACCT procedures a number of times. On 22 September, he told his mental health caseworker that he was having thoughts of self-harm and was using distraction techniques to manage them. The caseworker discussed this with staff on the unit, and they decided not to open an ACCT at that stage. However, although the caseworker made a note in his healthcare record, they did not document their discussion or decision in the wing observation book or in his prison record.
76. On the morning of 14 October, when the man was very anxious about giving evidence in court, staff made good arrangements for him to give evidence by video-link, which relieved his anxiety. He handed staff a blade and a noose, which he had made from a piece of sheet and said he had made the previous night. He indicated that, as he no longer had to appear in court in person, he had no intention of using it anymore.
77. Staff knew that the man had a history of self-harm, and discussed this. The discussion included a custodial manager, the mental health caseworker, an officer from the safer custody department, and staff who worked on Collingwood Unit and knew him well. The caseworker had also spoken to him and believed his assurance that he would not harm himself. Staff collectively decided not to begin ACCT monitoring at that stage. They recognised that his main concern had been going to court in person to give evidence so they decided to consider his risk again once he had given evidence. The caseworker made a routine mental health referral for a nurse to assess whether he needed additional support in the light of his recent stresses.
78. The production of a blade and a noose are quite alarming indicators of risk and, in most circumstances, we would expect staff to begin ACCT monitoring to provide the prisoner with extra support. Prison Service Instruction (PSI) 64/2011, which covers suicide and self-harm prevention, and Portland's suicide and self-harm protocol both instruct staff to begin ACCT monitoring whenever they receive information or observe behaviour which may indicate a risk of suicide or self-harm. However, we recognise that the man received appropriate support from staff that morning.
79. We consider that the staff judgements on 22 September and 14 October were reasonable, but they did not record the events or the reasons for their decisions, in the man's prison record or the unit observation book on either occasion. We would expect such important discussions and decisions about a prisoner's safety to be fully recorded. We make the following recommendation:

The Governor should ensure that staff note all important information and decisions about a prisoner's risk of suicide and self-harm in their prison record and wing observation books, including when staff consider, but decide not to open an ACCT.

Assessment of risk after court appearances by video-link

80. Based on their knowledge of the man, we recognise that the staff made a considered decision not to open an ACCT immediately on the morning of 14 October. However, we are concerned that no one formally assessed whether he needed the support of ACCT procedures after he returned from giving video-link evidence. Prison Service Order (PSO) 3050 notes that appearances at court can have a significant impact on the health of the prisoner and states that prisons should screen prisoners passing through reception for any potential healthcare or suicide/self-harm issues. The PSO recognises that there are other events that happen in prison that can have a significant impact on a prisoner and specifically refers to court appearances by video-link.
81. Prison Service Instruction 74/2011, which deals with reception arrangements, contains a mandatory instruction that "*Assessments must also be made of prisoners who by-pass some Reception processes owing to their late arrival or disruptive behaviour, and those whose status and demeanour may change after a court appearance via video link*". The man was appearing in court as a witness, so his status was not changing. However, it was possible that his mood and risk of suicide and self-harm could have changed as a result of giving evidence. Although staff said he appeared to have been relieved afterwards, there was no formal assessment of his risk, and staff were unaware of the details of what had happened when he gave evidence. That morning, the mental health nurse had made a routine mental health referral, but in the light of events that day and his history, we consider that a mental health nurse should have assessed his risk of suicide and self-harm again shortly after he had given evidence, to see whether he needed additional support. We make the following recommendation:

The Governor and Head of Healthcare should ensure that healthcare and other staff assess prisoners for risk of suicide and self-harm and other potential health issues after a court appearance by video-link.

The man's risk of suicide and self-harm before his death

82. Although the man had been seriously assaulted in the prison earlier in the year, there are no indications that he was subject to any ongoing bullying. Staff and prisoners who knew him had not witnessed anything to suggest this, and there were no intelligence reports indicating a problem. Although his alleged assailant remained at Portland, the two prisoners did not come into contact. He said that he was anxious about moving around the prison after the assault and officers accompanied him to collect his medication. By all accounts, he was settled and happy on Collingwood Unit.
83. There was no evidence that the man was using illicit drugs, which was supported by the post-mortem and toxicological examinations.
84. The man asked to see a Listener on the evening of the 23 October, but this was not unusual (this was the ninth time he had asked for a Listener in October). The Listener who spoke to him that night said he gave no indication that he was contemplating suicide. Other prisoners who lived in Collingwood Unit, and knew him well, agreed that they had not been concerned about him in the days before his death.

85. Although the man's general risk factors remained, there was little to suggest he was at raised risk of suicide immediately before his death and needed additional support. We do not consider that staff could reasonably have predicted or prevented his death.

Mental healthcare

86. The man did not always take his mental health medication as prescribed. His mental health caseworker said that this went in cycles: he took his medication, felt better and then would decide he did not need his medication. He would then feel unwell and start to take his medication again.
87. As in the community, prisoners are responsible for taking their medication as prescribed and healthcare staff cannot make prisoners take medication if they do not want to. Whenever the man decided to stop taking his medication, healthcare staff asked him to contact them if he felt unwell again. Normal practice at Portland was to speak to prisoners who did not collect their mental health medication for three consecutive days to check they understood what they were doing. He took his medication sporadically in October 2014. He did not take it for one three-day period from 17 to 19 October, but collected it again on 20 October. He did not collect it after that. The clinical reviewer concluded that he would not have expected healthcare staff to have done anything further in the circumstances.
88. The clinical reviewer considered that the man's risk management and mental healthcare was appropriate and at least as good as he could have expected in the community. The psychological support given to him was effective and led to a marked decrease in his self-harming behaviour. He commented that, in his view, a community based mental health team would have struggled to match the professional service that Portland's mental health team gave him, both in terms of quality and quantity. His medical record since he went to prison in 2011 shows he had more than 450 medical appointments.
89. Although in September 2014, the man said that he was feeling low and asked for his medication to be increased, the clinical reviewer noted that his medical records show no significant change in the frequency or type of contact during September and October. He said that there was no indication of a change in his mood and no symptoms that suggested a change in his suicidal thoughts or intention. He concluded that there was no reason for healthcare staff to have been extra vigilant on 23 October or immediately before.

Emergency response

90. PSI 03/2013 requires governors to have a two-code medical emergency response system based on the instruction (code blue and code red are recommended). Portland's medical emergency response protocol required staff to use code blue or code red, and using an emergency code should trigger the control room to call an ambulance immediately. However, night orders for staff dealing with medical emergencies or a suspected death did not include the need to use the appropriate emergency code and night staff did not realise that they needed to use them. When the night patrol officer found the man hanging, he radioed for immediate assistance but did not use an emergency code. As a

result, staff in the control room did not summon an ambulance until the night orderly officer arrived at the cell and specifically requested one – a delay of about five minutes. The delay did not affect the outcome for him, as he was already dead by this point. Night orders have since been amended and we are satisfied that the issue has now been addressed.

91. When the control room called an ambulance, the local ambulance service operator asked for more information about the emergency. On this occasion, there were sufficient staff on the unit to talk to the operator as they were not involved in giving emergency treatment which would usually be the case in other emergencies. The Head of Healthcare told the investigator that the local ambulance service would not send an ambulance without some personal details about the patient, which the control room did not always have in emergency situations. Although it did not cause any further delay in the man's case, this could do in future. PSI 03/2013 requires prisons to have agreed written emergency response protocols with the local ambulance trust so that they understand the prison context to help eliminate such delays. We make the following recommendation:

The Governor and the Head of Healthcare should agree a protocol with South Western Ambulance Service Trust to ensure they understand the prison context and that staff who request ambulances might not have immediate detailed information about the patient.

RECOMMENDATIONS

1. The Governor should ensure that staff note all important information and decisions about a prisoner's risk of suicide and self-harm in their prison record and wing observation books, including when staff consider, but decide not to open an ACCT.
2. The Governor and Head of Healthcare should ensure that healthcare and other staff assess prisoners for risk of suicide and self-harm and other potential health issues after a court appearance by video-link.
3. The Governor and the Head of Healthcare should agree a protocol with South Western Ambulance Service Trust to ensure they understand the prison context and that staff who request ambulances might not have immediate detailed information about the patient.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that staff note all important information and decisions about a prisoner's risk of suicide and self-harm in their prison record and wing observation books, including when staff consider, but decide not to open an ACCT.	Accepted	<p>A Local Governors Notice to Staff will be issued for the information of all staff.</p> <p>Guidelines surrounding the importance of evidencing risk based decisions and recording this information on PNomis and in wing observation books will be reinforced during ACCT training and refresher training. Awareness with staff will be re-enforced by the safer custody department weekly. Observation books will be up-dated with expectations. This will be monitored and recorded in our safer custody meetings.</p> <p>A management check of all ACCT documents will be completed weekly by the Safer Custody manager and the Night Orderly Officer to reinforce compliance</p>	<p>30th June 2015 Head of Safer Prisons</p> <p>31st August 2015 Head of Safer Prisons</p> <p>Management check in place</p>	Completed
2	The Governor and Head of Healthcare should ensure that healthcare and other staff assess prisoners for risk of suicide and self-harm and other potential health issues after a court appearance by video-link.	Accepted.	Staff will complete a form for all offenders attending video link evidencing outcomes and decisions, summarising events. All prisoners appearing in court by video link who have a change of circumstance, or who video link staff have any concerns about, will be seen by healthcare and a member of the safer custody team. Video link staff will be reminded of the fact that a court appearance that does not result in a change of circumstances can also have the effect of increasing the	30 th June 2015 Head of Safer Prisons	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			<p>risk of self-harm or suicide, and that it is their responsibility to be vigilant in their interactions with prisoners. They will be reminded that:</p> <ul style="list-style-type: none"> - where they identify a clear risk of self-harm or suicide an ACCT must be opened; - where they have some concerns or have received information that there may be an issue, but are not sure that an ACCT is warranted, they should refer the prisoner to a member of the Health Care and Safer Custody Team for a more detailed assessment of risk. 		
3	<p>The Governor and the Head of Healthcare should agree a protocol with South Western Ambulance Service Trust to ensure they understand the prison context and that staff who request ambulances might not have immediate detailed information about the patient.</p>	Accepted	<p>The protocol for calling emergency response codes is in place and compliant with PSI 03/2013. This is displayed around the prison on all residential areas and included in the night orders for night patrols.</p> <p>Discussions with the Health Care Manager, Safer Custody Manager and SWAST in agreeing a protocol are ongoing. The Area Safer Custody team will be providing support in the development of an agreed protocol.</p>	<p>Protocol in place Head of Safer Prisons</p> <p>1st September 2015 to have an agreed protocol in place with SWAST.</p>	Completed