PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMYOI Portland in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

February 2013

This is the report of an investigation into the circumstances surrounding the death of a man. He was only 20 years old when he died at HMYOI Portland in January 2012. He was found hanging in his cell during the morning roll check. I would like to offer my condolences to his family. I hope that this report provides them with a better understanding of what happened to him in prison.

The man had been in custody since October 2010. He was subject to a four month period of self-harm monitoring after a very serious attempt to take his own life at HMP Exeter in February 2011. He transferred to HMYOI Portland in June. During the next six months, he seemed to settle and get on well with staff on his wing. His behaviour deteriorated in January 2012 and he told a nurse that his mood was low. However, he did not alert staff to any suicidal thoughts and did not disclose some bad news that he had received. Although he had been subject to self-harm monitoring on three previous occasions, he was not being monitored when he died. He was found hanging in his cell one morning towards the end of January. He could not be revived and was pronounced dead in his cell by paramedics.

The investigation was completed by an investigator. The man's mother and father passed on their concerns to one of our family liaison officers. A clinical reviewer was appointed by the local PCT to complete a review of the clinical care the man received in prison.

The death of a young person in custody always raises serious questions, but we do not think that staff at Portland could reasonably have foreseen the man's actions or prevented his death. Nevertheless, lessons should be learned from this sad case. For example, there is scope for procedural improvements to self-harm arrangements at both Exeter and Portland, not least the protection of important documentation. At Portland, concerns from loved ones need to be passed on to wing staff, access to appropriate health care staff should be timely, emergency responses require enhancement and family liaison could be further improved.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2013**

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SUMMARY

1. The man had a history of mental health problems and offending. He was charged with a violent offence in October 2010 and remanded into custody at HMP Exeter. The following month, he was discharged from the mental health team's caseload without any contact. He saw a doctor later in November, who increased his dose of antidepressant medication. He was then subject to self-harm monitoring between mid-December 2010 and early January 2011, after he cut himself.

2. In late January, the man asked to speak to the mental health team. He saw a doctor in early February and then attended an assessment with a mental health nurse on 9 February, who referred his case to the next multi-disciplinary team meeting. On 14 February, he was found hanging in his cell after his partner ended their relationship. He was cut down, regained consciousness and was taken to hospital. He returned to Exeter a few days later and continued to be subject to self-harm monitoring for the next four months.

3. During March, April and May, the man was discussed at multi-disciplinary team meetings. He repeatedly made threats to harm his cellmate. Staff thought that he was probably trying to manipulate them so that they would move him to a single cell. Health care staff and officers tried to strike a balance between keeping his cellmate safe and making sure that he was not left alone to harm himself. The visiting consultant psychiatrist did not refer him to the mental health in-reach team because she did not think he was sufficiently unwell. However, she prescribed low dose antipsychotic medication to treat some residual symptoms of paranoia.

4. After he received a lengthy custodial sentence, the man transferred to HMYOI Portland on 14 June. A doctor ended his prescription for antipsychotic medication because he had not been taking it. He was referred to the primary care mental health team and engaged with them in early July, before declining further help.

5. In September, staff began self-harm monitoring after they became concerned about him. However, the safer custody coordinator ended monitoring the following day with his agreement.

6. The man re-engaged with the primary care mental health team in October. A healthcare assistant assessed him and, during November and December, completed four one-to-one sessions with him to help him manage his emotions and stabilise his mood. A doctor prescribed an antidepressant in December.

7. His one-to-one sessions with the healthcare assistant were supposed to continue in January 2012, but she was off work sick and nobody delivered the sessions in her absence. During January, staff noticed that his behaviour became more disruptive. He lost some of his privileges but, while he was sometimes angry, he could also be polite and apologetic to staff.

8. On the Wednesday, Thursday and Friday before he died on the Saturday, the man made a series of telephone calls to family and friends. He received a letter and an email from his former partner confirming that she did not want to resume a relationship with him. On Thursday, he asked an agency nurse for support because his mood was low, but he said he was not suicidal. She made an appointment for him with a doctor to review his antidepressant medication on the following Monday, because a GP was not available to see him before then.

9. The man was locked in his cell as usual on Friday evening. He did not tell staff that he was having suicidal thoughts and he was not subject to self-harm monitoring. He was checked by the night patrol officer at about 8.30pm but there was no requirement for the officer to check him again until the next morning. A member of night staff raised the alarm at 6.40am the next morning when he looked into his cell during the Saturday morning roll check and saw him hanging.

10. Prison staff entered the cell and cut him down. There was then a brief delay in beginning cardiopulmonary resuscitation (CPR) because some of the staff thought that he had already died and could not be resuscitated. He was initially left face down on the bed. However, an officer arrived and decided to perform chest compressions. Paramedics arrived at about 7.00am, told the staff to stop and pronounced him dead.

11. Although we think it would have been difficult for prison staff to predict the man's actions, we make 14 recommendations as a result of our investigation. Improvements need to be made to the self-harm monitoring and family liaison processes at Portland. We also make recommendations about the way in which mental health assessments are carried out and medication is prescribed. We also recommend that night staff should receive training so that they can deliver effective cardiopulmonary resuscitation in the absence of any nursing cover overnight. However, this is unlikely to have helped him, who appears to have died some time before staff found him.

THE INVESTIGATION PROCESS

12. The investigator was notified about the man's death on Monday 30 January. Notices were issued to staff and prisoners at HMYOI Portland telling them about the investigation process and inviting them to contact the investigator.

13. He began the investigation at Portland on Wednesday 1 February and returned to conduct interviews on Tuesday 28 and Wednesday 29 February.

14. He contacted the local PCT to ask them to commission a review of the clinical care the man received in custody. The purpose of the review is to establish whether the care which he was offered in prison was equivalent to that he could have expected in the community. A clinical reviewer completed the review.

15. The investigator wrote to the local Coroner at the start of the investigation. HM Coroner will be provided with a copy of our report.

The man's mother

16. One of our family liaison officers telephoned the man's mother on 23 February to discuss any concerns she had about her son's treatment. She told the liaison officer that she submitted several complaints about the way her son was treated while he was held at HMP Exeter. She felt very strongly that staff at Exeter did not look after her son properly.

17. She was under the impression that, after he attempted to hang himself at Exeter in February 2011, there had been a delay of more than three hours before he was taken to hospital. We have confirmed that he was taken directly to hospital after he was found hanging at Exeter and did not sustain any brain damage.

18. The man's mother also said that she was not informed about her son's attempted hanging until the following morning. She explained that she then received a call from the chaplain saying that her son was seriously ill and unlikely to survive. She felt that she should have been told in person and not over the telephone, as she then had to drive a long distance to the hospital in a very distressed state.

19. She wanted confirmation that all the information held by HMP Exeter about her son was passed onto the staff at Portland when he transferred. We discuss in the report that an important self-harm monitoring document was misplaced by staff at Portland after the man's transfer and the closure of the document.

20. She thought that he was subject to self-harm monitoring during the Christmas period. However, when he died, the man had not been subject to self-harm monitoring since September 2011.

21. The man's mother explained that her son became depressed and low in mood if he did not speak to her. She said that they had a close relationship and spoke all the time about how he was feeling. She told her son that she was moving house on 3 January 2012. Her telephone number changed and he did not call her again until 25 January.

22. During this time, she said that she called the prison on several occasions because she was worried that he was getting depressed and that he had no way of contacting her. She asked the prison to approve her new telephone number quickly, but she was told that the relevant department could not do this until her son had himself submitted an application. We address the problems she encountered in the 'Issues' section of the report.

23. She was also concerned that her son lost his enhanced privileges before he died and that this might have contributed to his depression. We include details about what happened in the 'Key events' section of the report.

24. The man's mother was appreciative that the Governor and family liaison officer at Portland broke the news of her son's death to her in person. She commented that his mood had seemed to improve while he was at Portland and he seemed to have been managing better.

The man's father

25. The family liaison officer and investigator met the man's father at the offices of his solicitor on 26 April. His father outlined a number of concerns about the care his son received.

26. He asked for more information about his son's mental health diagnosis and treatment and questioned whether this information was properly shared to help him. He wanted to know which prisons he had been held at. He asked why he had transferred to Portland and whether the transfer was appropriate in light of his mental health problems.

27. The man's father asked particularly about the mental health treatment and medication his son received at Portland. He wanted more information about his previous attempts to harm himself and any periods of self-harm monitoring. He wanted to know if he had been sufficiently mentally unwell to warrant sectioning under the Mental Health Act. (We have established that he was not diagnosed with a mental illness and was not deemed sufficiently unwell to warrant treatment under the Act.) He requested more information about what happened to his son in January before his death. He also asked for full details about the emergency response when his son was found hanging in his cell at Portland.

28. He was also upset about the way in which he learned of his son's death. He asked why staff at Portland, the Coroner's office and the Prisons and Probation Ombudsman did not get in touch with him when his son died. We address the reasons for this in the 'Issues' section of the report.

29. The man's mother, grandparents and father were provided with copies of our draft report. We have included their responses to the draft.

HMYOI PORTLAND

30. Portland is a Young Offender Institution (YOI) with a maximum population of 483. It mainly holds young men aged between 18 and 21 years, but it has also begun to take some older prisoners who live in separate accommodation. Many of the buildings date back to the 1800s. The prisoners live on seven house blocks; Benbow, Raleigh, Drake, Nelson, Grenville, Collingwood and Beaufort. Grenville is the induction unit.

31. The man lived on Benbow House, which has four landings and holds up to 91 prisoners. During the day, between Monday and Friday, two officers normally patrol Benbow House and a senior officer manages the regime.

Healthcare provision

32. During the week, healthcare staff are on duty between 7.45am and 5.15pm. At the weekend, one general nurse, one mental health nurse and two healthcare assistants work during the day between 8.15am and 5.15pm. Healthcare staff do not work in Portland overnight.

33. A doctor visits to hold surgeries from Monday to Thursday and for emergency appointments on Fridays. There are no GP surgeries at the weekend. Prison staff use an out of hours telephone service when there are no doctors or nurses on site.

34. Healthcare services at Portland are provided by a NHS Foundation Trust. A primary care mental health team treats patients with low level depression, low mood or anxiety. It is based in the prison and treats the same kind of mental health problems as a GP in the community. The team comprises two full time mental health nurses and two half-time healthcare assistants.

35. A mental health in-reach team, which treats patients with secondary care needs who would normally be treated by a Community Mental Health Team, is based at a clinic in Dorchester. Members of the team visit the four prisons in the local area; The Verne, Dorchester, Guys Marsh and Portland. They treat prisoners who have been diagnosed with severe and enduring mental health problems.

Staffing overnight

36. At night, Operational Support Grade staff (OSGs) work on each of the seven residential units. One OSG also works on the gate and another in the segregation unit. There are also three or four officers on duty, normally overseen by a senior officer who is in charge of the prison, based in a central office. The OSGs do not carry keys to move around the prison. Benbow House, Raleigh House and Drake House have interconnecting doors. The OSGs on duty overnight on these units can move between the three houses to help each other. However, they are locked within this three house unit.

37. The OSGs carry a cell key in a sealed pouch to be opened in emergencies or life threatening situations. In such circumstances the preservation of life takes priority and prison staff should break the seal, unlock the door and enter the cell alone, subject to a rapid risk assessment. Before entering a cell they are expected to radio colleagues.

Her Majesty's Inspectorate of Prisons

38. Her Majesty's Inspectorate of Prisons (HMIP) completed an announced inspection of Portland in July 2009. The then Chief Inspector of Prisons, wrote:

> 'Until fairly recently, staff attitudes and approach were… negative and outdated. This inspection, however, found a prison which had changed both its outlook and its outcomes: with a focus on trying to provide a positive and rehabilitative experience for the young men placed there…
>
> 'Young offenders' institutions are intrinsically volatile places. Portland was no exception, with a significant number of violent incidents and uses of force. Positive efforts had, however, been made to reduce violence and bullying and to prevent self-harm and suicide.
>
> 'There were appropriate suicide and self-harm prevention systems and data was effectively analysed… Assessment, care in custody and teamwork (ACCT) documentation and management were reasonable, but there was no effective quality assurance… the lack of a Listener suite was a significant omission.'

At the time of the inspection mental health services were suffering from staff shortages with primary mental health services provided by one dual-qualified nurse.

Independent Monitoring Board

39. The most recent annual report published by the Independent Monitoring Board (IMB) at Portland covers the year from April 2010 to March 2011. (The IMB at each prison is made up of unpaid volunteers from the local community who monitor the day-to-day life in the prison to help ensure that proper standards of care and decency are maintained.) The IMB wrote:

> 'Portland is on the threshold of a period of great change. Conditions of custody for prisoners at Portland have improved manifestly over the past three years; progress perhaps reflected in the reduction… in the number of applications received by the Board. The IMB hopes that the YOI will be able to maintain its positive momentum despite the considerable challenges [it faces]…'

Previous deaths

40. In November 2008, this office investigated the death of another young man who was found hanging in his cell at Portland. When the young man died, no concerns had been raised about the risk of him taking his own life. He had just received a lengthy custodial sentence and had only transferred from the London area a few days earlier (whereas the man was from the south west of England and had been at Portland for a number of months when he died). We did not make any recommendations in that case which are relevant to the circumstances of the man's death.

KEY EVENTS

41. The man had served sentences in secure training centres as a child. He first came before the courts aged 12 and was subsequently categorised as a Prolific or Priority Offender (PPO) by the criminal justice system because he had committed nearly 50 offences, several involving serious violence.

42. He suffered with mental health problems and was under the care of his local community mental health team (CMHT). He was diagnosed with an anti-social personality disorder in 2008. He had previously been prescribed citalopram (an antidepressant) and risperidone (an antipsychotic). He first tried to take his own life at the age of ten and did so again shortly before he was arrested and taken to HMP Exeter.

2010

HMP Exeter

43. The man committed a violent offence in the early hours of 4 October 2010. He was arrested and appeared at Magistrates' Court the next day, 5 October. He was remanded into custody and taken to HMP Exeter. Reception staff completed a cell sharing risk assessment (CSRA) and determined that he presented a low risk of harm to potential cellmates. The officer recorded that he had recently tried to hang himself but was now 'over this episode' and was not having any suicidal thoughts.

44. The next day, 6 October, the man's probation officer in the community emailed prison staff to advise them that the man might present a risk to other prisoners because he was known to hold extreme right wing and racially discriminatory views. He also informed prison staff that the man might try to harm himself. He was not made the subject of self-harm monitoring at this time, nor is there evidence that staff completed a new CSRA or moved him to a single cell from the double cell he was in.

45. The man appeared at Crown Court on 19 October. On 28 October, he received a four week custodial sentence at Magistrates' Court for an unrelated offence of possessing an offensive weapon. Because he was already being held on remand for the more serious offence, he remained in prison after this short sentence expired.

46. On 9 November, it was noted in his clinical record that he was discharged from the care of the mental health in-reach team without any contact. On 15 November, he submitted an application to see a doctor:

> 'I suffer from major depression and my meds don't work anymore. I can't sleep at night and I'm starting to feel extremely aggressive.'

47. A doctor assessed him on 18 November. He said that he was not sleeping and was missing her girlfriend. He said he was having suicidal thoughts but denied having made any specific plans. The doctor did not begin self-harm

monitoring. He recorded that the man had been taking citalopram since March. He doubled his dose and planned to review him two weeks later. There is no record that this review took place.

48. The man was subject to Assessment, Care in Custody and Teamwork (ACCT) self-harm monitoring from 18 December. An officer opened the ACCT document after he cut his ear lobe with a razor blade. He explained that he had done this because staff would not listen to his requests for a move to a different wing. The officer completed an ACCT assessment interview with him at about 5.30pm that evening. He said that he was not having suicidal thoughts. The same day, 18 December, he was moved to another wing and shared a cell with a different prisoner. Wing staff planned a referral for a mental health assessment, making a note of this in the first ACCT case review and the ACCT care map. The case manager wrote that the ACCT document would remain open for one week until the outcome of the mental health assessment was known. There is no evidence in his clinical record that a mental health assessment was completed during this period.

49. When staff held an ACCT review meeting on 24 December, the man told them that he had stopped taking his citalopram two weeks earlier. Consequently, the officers decided to continue self-harm monitoring until the New Year while his mental health issues were addressed. A mental health nurse attended the ACCT review and agreed to make an appointment for him with a clinical psychologist.

50. At an ACCT review meeting on 31 December, the man told staff that he did not want to restart his citalopram prescription and no longer wanted to be subject to ACCT self-harm monitoring. The case manager reduced the frequency of checks but told him that ACCT monitoring would not end until a mental health review had been completed.

2011

51. At 11.30am on 6 January 2011, the man asked to be moved to a single cell. He told staff that his anger issues were becoming worse and he feared that he might assault his cellmate. The officer who he spoke to completed the relevant form requesting a move. At 5.30pm, the same officer recorded in the ACCT document that ‘unfortunately’ he ‘did not get CSRAed to a red card’ (in other words a cell sharing risk assessment had not resulted in a move to a single cell) ‘in large part’ because he was still subject to ACCT self-harm monitoring.

52. Staff closed the ACCT document the following day, 7 January. The mental health nurse attended the review meeting. All present thought that the man had settled in well on his new wing. He told the meeting that he was not thinking about harming himself. The case manager recorded that he was now ‘over his issues which caused him to self-harm’ and that all present had agreed that the ACCT document should be closed. There is no evidence in his clinical record that his mental health was reviewed before ACCT monitoring ended, as had been the intention on 31 December. An ACCT

post-closure review was planned for 13 January but there is no evidence that this took place. He made another appearance at Crown Court on 14 January.

53. On 26 January, he submitted an application to see the mental health team. On 7 February, he saw a doctor and told her that he was thinking about harming his cellmate. He wanted to be assessed as a high risk to other prisoners so that he would be moved to a single occupancy cell and no longer have to share. The doctor took note of a reported diagnosis of antisocial personality disorder. She also recorded that he was waiting for a psychiatric review in the community for a possible diagnosis of bipolar disorder. He became agitated when she told him that he did not meet the medical criteria for single cell occupancy. The doctor referred him for a mental health assessment to explore his possible diagnosis of bipolar disorder.

54. A mental health nurse completed a mental health assessment with him on 9 February. He reported sudden mood swings. He said that he had tried to take his own life in September 2010 and he thought that citalopram made him more violent. The nurse recorded that his case was to be discussed at the next healthcare multi-disciplinary meeting. He noted that he had not requested, and did not require, any medication for the time being.

55. The man received a visit from his mother and his partner at 2.45pm on 14 February. During the visit, his partner indicated that she wanted to end their relationship. He was now living on his own in a double occupancy cell, although the reasons for this decision are not made clear in the records. At about 9.50pm that evening, he was found hanging in his cell with a torn bed sheet around his neck. His face was blue, but he began breathing again once staff removed the bed sheet. He had also made cuts to his wrist.

56. He was revived, staff called an emergency ambulance and he was taken to nearby hospital at about 10.00pm. During the next couple of days, he underwent scans which confirmed that he had not sustained any spinal or brain injuries.

57. His care was discussed at a healthcare multi disciplinary team meeting on 16 February. The healthcare manager recorded his ‘history of impulsive behaviour and deeply ingrained maladaptive patterns of behaviour with anti-social traits’. (In other words, ways of coping with difficult situations which are not helpful, such as becoming withdrawn or converting anxiety into anger.)

58. On 17 February, the man returned to Exeter from hospital and was assessed by a doctor. He was subject to ACCT self-harm monitoring as soon as he returned to the prison. The ACCT monitoring period lasted for the next four months. Although the investigator obtained some information about this period of ACCT monitoring from other sources, the ACCT document itself was subsequently lost after he transferred to HMYOI Portland in June and was therefore not available to assist and inform our investigation. Only a few duplicated pages which had been faxed to Portland before his transfer now exist.

59. He initially stayed in the healthcare centre. He was prescribed sertraline (a different antidepressant) and his behaviour was described by a doctor as 'acutely agitated'. To begin with, he was not allowed to shave with a razor unaccompanied, and staff checked him every 20 minutes as part of his self-harm monitoring. The frequency of these checks was reduced on the advice of a doctor on 18 February and he was instead checked at least once an hour.

60. The same day a caseworker for the man's local MP in North Devon wrote to the prison after the man's grandmother had got in touch:

> 'I have tried repeatedly to make contact with someone in authority at Exeter Prison to determine exactly what the level of observation and care is for him in order that some reassurance may be given to his grandmother and mother.
>
> 'I would be grateful if this matter could be treated with some urgency and that steps are taken to reassure the family.'

61. The healthcare manager replied to the man's caseworker the same day, stating that the staff were working hard to ensure his recovery in the healthcare centre. He wrote that he was subject to enhanced observations and was engaging well with the nurses.

62. On 20 February, the man told an officer that if he didn't speak to someone soon, he would start hurting people. He also stated that it was more fun hurting other people than hurting himself.

63. A visiting consultant psychiatrist met the man to complete a psychiatric review on 23 February. He described how, following his unsuccessful attempt to persuade a doctor that he should be moved to a single cell, he had persuaded a senior officer to move him after stating that he would cut his cellmate's head off. She reminded him that he could not remain in a single cell because of his recent attempt to take his own life.

64. The psychiatrist found that his mood was normal, neither low nor high. His reactions during their conversation were appropriate to what was being said. He said that he was not currently having any suicidal thoughts. She found no evidence of any psychotic symptoms. In other words, he was not hearing or seeing things, was not delusional and was not experiencing hallucinations. She noted that he had good insight into his condition. He was realistic about his situation and understood what could be done to help him. She diagnosed traits of histrionic and dissocial personality disorders. By this, she meant that he found his emotions hard to deal with.

65. She advised that he was fit to return to normal location on the wings. She suggested that her assessment be shared with the safer custody team. She thought it highly likely that he would use self-harm as a means of controlling his external environment. She recommended that he share a cell with another prisoner.

66. The psychiatrist stopped his prescriptions for zopiclone (sleeping tablets) and chlorpromazine. She explained to the investigator that chlorpromazine is an old-fashioned antipsychotic medication which was only being prescribed at the time in a low dose to act as a sedative. She thought that his prescription was inappropriate and stopped this drug because it has side effects. It would not have helped him in any case because he did not have any psychotic symptoms. She concluded:

> 'No interventions / treatment appropriate from mental health team so will not be on caseload, however we are happy to be contacted to join in ACCT assessments on this gentleman as his behaviour is likely to remain problematic.'

67. She thought that it was best for him to live a normal life on the wing. She did not think that he had a psychosis or a sufficiently serious mental health problem to warrant referral to the mental health team. She thought it important that he became confident in his ability to cope independently, albeit with the support of the safer custody team.

68. On 24 February, staff reviewed the man's ACCT document before he was discharged from the healthcare centre and moved back to the wing. ACCT self-harm monitoring continued for the next few months at Exeter.

69. On 20 March, wing staff asked a mental health nurse to speak to him because they were worried about him. However, he refused to engage with the nurse. Two days later, on 22 March, a mental health assessment was requested:

> 'He has approached landing staff – he has reached an all time low – he feels like he has nothing to live for. He has not taken his medication for three days.'

70. A doctor assessed him the same morning. He had threatened to take his own life and was asking to return to the healthcare centre. When the doctor asked him to speak up because he was mumbling, he stormed out of the consultation. The doctor arranged for officers to perform more frequent ACCT checks until a mental health nurse assessed him. The doctor thought that he was possibly manipulating the situation for his own ends, but also considered that he had the potential to harm himself.

71. Half an hour later, a doctor arranged for him to be readmitted to the healthcare centre. He had told her that he wanted to die and planned to take his own life that day. He was now checked every 15 minutes.

72. The next day, 23 March, a doctor assessed him. He told her that he had never intended to harm himself the previous day, but had claimed that he would in order to engineer a move to the healthcare centre. He told the doctor that he did not plan to harm himself. She decided that he should return to the wing and that ACCT monitoring should stop. (Although he returned to live on the wing, ACCT monitoring actually continued until June.) She

recorded that he had a significant history of self-harm after receiving bad news.

73. On 29 March, there was a fight on the wing between two opposing groups of young men. The man needed to be restrained by staff after running down the landing towards the fight with a piece of wood in his hand. Later that day, after visiting her son, his mother told officers that he had asked her to say that he was 'a dead man walking' and that 'Plymouth Boys had declared war on Barnstaple Boys'. He had told his mother that he was either going to kill somebody or be killed. (He was apparently part of a gang of young men from the Barnstaple area.)

74. On 3 April, the man's mother wrote to the Governor of Exeter:

> 'Dear Governor,
>
> 'I write to you with more concerns of the welfare of my son. I know you are aware of the current issues that are going on within the wing. As a mother my only concern is for the safety of my son. I understand he has requested a transfer to [a prison in the region where his grandparents lived].
>
> 'I would very much appreciate it if you would indeed grant his request as in the long term this transfer would be beneficial to his safety and also to our family as my parents live in [another part of the country] and as soon as my house is sold I too will be living in [the same area]. Therefore, it will enable me to continue the constant support towards my son which is vital in his present state of mind.'

75. On 8 April, the man's probation officer wrote to him to explain that a transfer to his nominated prison was not yet possible because he had not been sentenced and his mother had not relocated to the area where his grandparents lived. After sentencing and his mother's relocation, the probation officer said that a transfer might be arranged. He encouraged him to speak to his mother about her plans.

76. During an ACCT review meeting the same day, the man told staff that he was 'a neo-nazi extremist'. He said that he was receiving 'non-stop threats from the Plymouth prisoners' and that there was 'a price on his head'.

77. On 19 April, he made another request to see a doctor in which he said:

> 'I am finding it extremely hard to sleep and quite often only manage 3 or 4 hours sleep in 24 hours. I'm depressed and have thoughts of suicide. I'm so stressed and I just don't know what to do. I'm on an ACCT so you might want to look at that if it will help with my appointment.'

78. His healthcare was discussed at a multi-disciplinary meeting on 27 April. He had been telling staff that he intended to harm himself. At the time, he was

refusing to speak to the ACCT assessors. A psychiatrist confirmed that he was not taking any medication since she stopped the prescriptions for zopiclone and chlorpromazine. She explained to the investigator that he remained a troubled young man but that he was recovering relatively quickly from his suicide attempt in February.

79. She did not think that an antidepressant would be clinically effective for him, but she saw no harm in one being prescribed if it put his mind at rest. She wrote guidance in the clinical record for any healthcare staff reviewing him. She noted that her mental health assessment from 23 February should again be shared with the safer custody team by the mental health coordinator, that ACCT self-harm monitoring should continue and that a gated cell was available in the healthcare centre if he required constant supervision. She added:

> 'Not on [mental health team's] caseload but team able to advise safer custody – may require a professionals meeting to share risk information.'

80. A doctor assessed him on 4 May. They discussed his anger management problem and the doctor provided him with relevant literature. He said that he was not currently thinking about harming himself.

81. On 6 May, the psychiatrist reviewed him again. His mood was different this time and he wanted to talk. He wanted to get better and she was keen to encourage this. She thought that the priority was for him to stop misusing substances. He sometimes woke up and still felt that he was dreaming, and was very sensitive to noise. She diagnosed a mental and behavioural disorder related to his misuse of multiple different substances. She believed that his substance misuse from his early teenage years had resulted in residual feelings of paranoia.

82. The man told the psychiatrist that he had spoken to a governor and would be going to a prison in the area where his grandparents lived after he was sentenced, because of 'trouble with gangs' locally. She decided to prescribe a low dose antipsychotic (risperidone) on a trial basis to treat any lingering symptoms of paranoia and help him cope during his sentence. If the drug proved effective, she intended that he would take it for a few months. There was no need for him to take this medication in the longer term.

83. The psychiatrist recommended that ACCT self-harm monitoring continue. She noted that he remained 'at risk of impulsive self-harm as [he] habitually responds to stress like this'. She also wrote that he would be moving to a different prison after he was sentenced, and that he should be referred to that prison's mental health team during the reception process because they would need to review the effectiveness of the antipsychotic medication she had prescribed.

84. The man began a 28 day prescription for risperidone on 7 May. He was supposed to collect a dose of this medication from the dispensary each day,

but stopped attending the medication hatch on 22 May. Although another 28 day prescription began on 7 June, he still failed to collect his risperidone. There is no evidence in his clinical record that healthcare staff spoke to him about his medication or took any steps to address his non-compliance with taking it.

85. At Crown Court on 10 May, he received a four year custodial sentence for offences of unlawful wounding (cutting his victim's hand with a knife while drunk) and using racially threatening words and behaviour (he had racially abused a doctor in the police station after his arrest). The court imposed an additional year's custody as part of an extended sentence (a sentencing option for these types of violent offences). He had already served 203 days while on remand.

86. A doctor assessed him again on 18 May. The risperidone had made him drowsy but he was tolerating the medication. The doctor and psychiatrist discussed the case and agreed that he was more likely to harm himself spontaneously than another prisoner. They concluded that he would be at a higher risk in a single cell, so he remained in a shared cell.

87. On the evening of 24 May, he was moved to a single cell overnight after threatening to throw a bucket of boiling water over himself unless he was moved from his shared cell. The next day, his case was discussed again at the healthcare multi-disciplinary meeting. ACCT self-harm monitoring continued. The psychiatrist recorded the following information:

> 'Discussion regarding the balance between concern over his impulsive self-harm and threats of harm to others – officers aware that health have told him he is in control of his actions and that should he assault a cellmate he will face consequences from his behaviour, there is no medical reason for a single cell and some medical reason to remain sharing as a safety net against further self-harm. However, this is up to wing staff to manage and contain and should they be able to increase observations in a single cell to contain risk of self-harm this is a reasonable decision though should be kept under review.'

88. On 25 May, a governor chaired an ACCT case review with two senior officers and completed a new cell sharing risk assessment (CSRA). The man explained to them 'in graphic detail' how he would violently assault a cellmate. The panel increased the risk he presented to other prisoners to 'high risk, single cell'. The new CSRA took into account advice from the mental health team, previous assaults on cellmates and his history of racially motivated offending. The panel concluded:

> 'The psychiatrist had stated that there is no medical reason for a single cell and that in her opinion the risk of self-harm was greater than harming a cell mate. However, during the review the team felt that the risk of self-harm is manageable in a single cell by a period of increased observations and a care map. This would balance the risk posed to any cellmate.'

89. On the morning of 26 May, the man punched another prisoner in the face in the exercise yard. It is not clear from the records whether there was a disciplinary response.

90. Following his sentencing, he was due to move to HMYOI Portland. He indicated that he did not want to transfer there, but he did not explain why. Staff understood that he eventually planned to move away from the South West of England to the area where his grandparents lived when he was released.

91. At an ACCT review meeting on 6 June, staff recorded that he was coping very well and had 'made a great deal of progress and the change is vast'. The frequency of ACCT observations was lowered, but he was still being checked at least once an hour during the night.

92. He completed a 30 hour course entitled 'Confidence and Anger Issues' while he was held at Exeter.

HMYOI Portland

93. The man transferred to Portland on 14 June. A mental health nurse assessed him during the reception process. (Portland's policy is for each new prisoner to be assessed by a general nurse and a mental health nurse.) She recorded that he was not having suicidal thoughts, but also noted that he had tried to hang himself in February after his relationship with his partner ended. She added that he had previously assaulted his cellmate. She referred him to the primary care mental health team.

94. A Principal Officer (PO) (the safer custody coordinator) closed the ACCT document which had been open since February on the day the man arrived at Portland. The existing pages of the document which the investigator has seen appear to indicate that he had attended 18 ACCT review meetings at Exeter since February. He told the PO that he was not having any current suicidal thoughts, that he no longer wished to be subject to ACCT monitoring and that ACCT checks were not helping him.

95. He moved into a cell in Grenville House, the induction unit. A mental health nurse and the wing manager completed a new CSRA and assessed that he presented a high risk to any potential cellmate. An officer completed a first night questionnaire with him, who said he thought he had anger management issues rather than a personality disorder. He expressed a wish to complete an anger management programme. He told the officer that he had not taken his medication for some time.

96. A doctor saw him the same day. She did not continue his prescription for risperidone because his compliance was 'very poor' and he had not taken it for about three weeks. (Non-compliance with a drug like risperidone would be a more significant issue if the patient was being prescribed the medication for

its antipsychotic properties. However, the psychiatrist's intention was to regulate his mood.)

97. On 21 June, he was informed that he was ineligible for early release on the home detention curfew (HDC) electronic tagging scheme because he was serving a sentence of four years or more.

98. On the same day, the man's probation officer completed an OASys assessment of the risk he presented to himself and to others. He recorded that there was a risk of him harming himself. (OASys is an electronic risk assessment tool. It uses information about the offender's lifestyle and previous offending behaviour to determine the likelihood of further offending and the risk of harm the offender presents to himself and others.)

99. On 24 June, a seconded probation officer (also the man's offender supervisor in the prison) met him to draw up a sentence plan. He told her about his history of mental health problems and that he had previously been diagnosed with an anti-social personality disorder. He told her that he did not want to take any medication and refused to do so for fear of being labelled as mentally ill. He indicated that he was not currently thinking about harming himself. The same day, she referred him to the primary care mental health team and he agreed to speak to a mental health nurse.

100. She also referred him to the 'Controlling Anger and Learning how to Manage it' (CALM) course and the 'Thinking Skills Programme' (TSP). During their discussion, he recognised his history of violent offending under the influence of alcohol and expressed a willingness to work with the Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) team. (There is a CARATS team in each prison working with prisoners who misuse either drugs or a combination of drugs and alcohol.) She made a referral to the CARATS service the same day, 24 June.

101. She also agreed to refer him to the 'Alcohol Related Violence (ARV)' course. She was impressed with his motivation to complete offending behaviour programmes. She told the investigator that he was very proactive and had a clear idea about his sentence plan. He told her that he wanted to change. She was surprised by how motivated he was, given his recent troubled history.

102. On 4 July, the man attended a mental health assessment with a healthcare assistant working with the primary care mental health team. He was recorded as engaging well at the meeting, but she did not manage to complete a full assessment due to his extensive mental health history. She planned to meet him again to complete her assessment. He insisted that he did not have a mental illness or a personality disorder, but rather an anger management problem. He was no longer being prescribed any medication for his mental health problems.

103. On 12 July, the man's probation officer visited Portland with a PC for an hour long meeting with the man's offender supervisor and the man himself.

104. When the healthcare assistant met the man again on 18 July, he refused to engage with her, and said he would gain nothing from working with the mental health team. She told him that he could apply for a further assessment if he changed his mind. He was therefore discharged from the care of the primary care mental health team the same day. During a racist offender workshop the same day, he expressed 'strong fascist and anti-semitic views'.

105. A doctor saw him again on 20 July. He refused to discuss his mental health problems but told her that he was not having suicidal thoughts. On 21 July, he moved from Grenville House to Benbow House, a standard residential unit.

106. During July, a member of the CARATS team assessed him and planned interventions to help him deal with his alcohol misuse problem. He was given alcohol awareness worksheets to complete in his cell and was also referred to an alcohol awareness group. CARATS staff did not think that he engaged well with the cell work he was given.

107. On 19 September, he moved to a different cell on Benbow House, 2-13. He lived on his own because of his assessed as a high risk for cell sharing.

108. On 21 September, his offender supervisor told him that, although he had been discharged by the primary care mental health team, he could re-engage with the team at any time. The same day, an officer began ACCT self-harm monitoring at about 10.50am because of his 'anger issues when things are not right for him'. He had returned from work in a low mood and had expressed suicidal thoughts. On the 'Concern and Keep Safe' form, the officer noted his previous attempt to take his own life at Exeter. Staff initially checked him at least once an hour. An administrative officer completed an ACCT assessment interview with him at 3.15pm. He told her that he wanted to be left alone and did not want to discuss the reasons for his distress.

109. At 10.00am the next day, 22 September, the PO went to see him on the wing. The PO had already spoken to a mental health nurse on the telephone. She advised the PO that a healthcare assistant had seen him in July but that he had been reluctant to engage.

110. The man was agitated and pacing the cell. He told the PO that he was annoyed by the opening of the ACCT document. He felt that he was being punished because he had made a rash comment to an officer which had been taken too seriously. The PO took him for a walk to the library and back to allow him to calm down. By the time they returned to the wing, he appeared much more relaxed. The PO then conducted the first ACCT case review with him and the officer. The case manager, a Senior Officer (SO), was not at work that day. The PO decided to close the ACCT document after the first review and made the following remarks:

> '[He] calmed down considerably and was very open with me. He has no thoughts of self-harm and admits his anger makes him say and do

things that are disproportionate to the event. I do not feel he needs to be on this document.'

111. A post-closure ACCT plan was completed and officers checked him daily for the next week. The PO and an officer then completed a post closure ACCT review with him on 29 September.

112. On 4 October, the man was told that there was a long waiting list for the ARV programme and that the earliest date he might begin the course would be January 2012.

113. The healthcare assistant met him to complete another mental health assessment on 10 October. She found no evidence of a mental illness and recorded that his main concern was anger management. He engaged well and agreed to begin sessions using the 'Emotional Wellbeing' toolkit.

114. The toolkit is a pilot scheme being run by the primary care mental health team at Portland. It is based on the experiences of service users who have experienced mental health difficulties themselves. The aim is to encourage the client to find ways of managing their emotions, mood, thoughts, feelings and behaviour. The toolkit uses elements of cognitive behavioural therapy (CBT helps patients to learn to recognise their patterns of behaviour and make alternative choices). It involves talking and some written 'homework', but no medication.

115. An officer became the man's personal officer in November. On 22 November, the healthcare assistant met the man to complete the first session of the 'Emotional wellbeing' toolkit. A healthcare support worker (HSW) met him on 2 December to discuss his alcohol misuse and engagement with the CARATS team.

116. The man began a brick laying course in early December. The practical element of the course ran in the afternoons from Monday to Thursday. The instructor told the investigator that he attended regularly and was enthusiastic. He wanted to pursue a career in construction. He displayed a positive attitude and never spoke to the instructor about possibly harming himself or feeling depressed.

117. At the start of December, a retired member of prison staff, who was working as a supply teacher at Portland, began teaching the academic element of the brick laying course to some of the prisoners who were studying for their diplomas. The man was one of his pupils. The teacher ran his class every morning from Monday to Thursday.

118. During the next two months, the teacher told the investigator that the man went from being a problematic member of the class to his best performing pupil. He took work away to complete in his cell and seemed very proud of what he had achieved. He was eventually obtaining top marks. He explained to the investigator that he occasionally had to reprimand him and take him out

of the classroom when he lost his temper, but he stressed that he always apologised and was generally making very good progress on the course.

119. On 5, 6 and 12 December, the healthcare assistant met the man to complete the second, third and fourth sessions of the 'Emotional wellbeing' toolkit. On 6 December, she wrote:

> 'he has removed the majority of the suggested questions from the tool kit but has replaced them with song lyrics that have meaning to him, he went through the tool kit with me explaining what each thing meant to him, he has been very creative using the tool kit in this fashion. One of the song lyrics spoke about low mood and depression and he explained he has felt this way for a very long time and now knows no other way to feel. He spoke about antidepressant medication he has been on before has made him feel drowsy which he dislikes. His PHQ9 [depression assessment tool] is indicative of depression and he presents in this way by being non-reactive to situations. We discussed in length the possibility of him starting antidepressant medication and the benefits this may have for him along with support from the mental health team in the way of the [emotional wellbeing] tool kit and positive thinking education.'

120. The same afternoon, the healthcare assistant spoke to a doctor, who then prescribed him fluoxetine (an antidepressant) apparently without meeting him. On 9 December, his offender supervisor recorded that he was 'doing very well' and that staff had achieved a breakthrough because he was now willing to work with healthcare. She noted that he was still sensitive about being labelled as somebody with mental health problems.

121. At his fourth 'Emotional wellbeing' session on 12 December, the man told the healthcare assistant that he had not started taking fluoxetine yet because he did not want to feel like he had been 'beaten'. She persuaded him to start taking the antidepressant medication the next day.

122. His request for a day release visit to nearby Weymouth (release on temporary licence, or ROTL) was refused in December. Although his probation officer supported the move, his application was turned down because of his status as a Prolific or Priority Offender, his previous poor compliance with court orders, his discriminatory views, the fact that he had only just started working with the mental health team and the lack of support for unescorted ROTL from his offender supervisor. She thought that he should complete the ARV programme before applying for supervised ROTL. She thought that he might subsequently be in a position to apply successfully for unsupervised ROTL.

123. On 20 December, the violence reduction coordinator completed a new CSRA and assessed that the man continued to present a high risk to any potential cellmate. (A prisoner's CSRA is reviewed six months after they arrive at Portland.)

124. While he continued his brick laying course, the man had several outbursts in the classroom when he struggled to control his temper. On one occasion, around Christmas time, the teacher told the investigator that he made a number of threatening remarks in front of the class. While the majority of the comments were threats to others, in front of the class he also alluded to what might happen if he was to take his own life. He took him outside the classroom and asked him about his remarks. He reassured him that he did not intend to harm himself and would never give others the satisfaction.

125. The teacher decided that it was not appropriate to open an ACCT self-harm monitoring document because he considered that the man had made an off-the-cuff remark among a number of other comments which consisted mostly of threats to others. However, afterwards he asked a prison officer on the education unit to speak to the staff on Benbow House about the comment. He was not aware of his previous attempt to take his own life at Exeter. A couple of days later, the officer told him that he had passed on his message and that staff on Benbow House would be keeping an eye on him. However, there is nothing in his prison record to show that the teacher's information was either passed on or acted upon.

126. In late December, the man's personal officer recorded that he was doing well and had earned his enhanced status under the Incentives and Earned Privileges (IEP) scheme. (The IEP scheme rewards prisoners for good behaviour and compliance with sentence plan targets. Prisoners are either on the basic, standard or enhanced regimes.) The officer noted his enthusiasm and encouraged him to keep up the good work. He was a regular user of the gym. On 30 December, he took part in a strongman competition in the gym, and won the 'Hang tough' event.

2012

127. After sustaining an injury, the healthcare assistant was unexpectedly away from work during January and February 2012. In her absence, the one-to-one work that she had planned to complete with the man was not continued by a colleague. (She had intended to finish the emotional wellbeing toolkit and support him as he got used to the effects of fluoxetine.) When it became clear that her absence would last for a couple of months, we were told that her work was reallocated, but no additional sessions were offered to him before he died.

128. A SO made an entry in the man's record on 3 January. She wrote that, although he was polite, he was also very angry at times.

129. On the same day, his offender supervisor recorded that he would begin the ARV course in March or April, allowing him time to complete his bricklaying course first. She told the investigator that he had been due to start the ARV programme in January but deferred because of his dedication to his bricklaying course. She had initially referred him to the ARV, TSP and CALM programmes, but she thought that the ARV course would represent the most relevant and appropriate intervention for him. She explained to the

investigator that he had kept an open mind about ways in which he might address his anger management problem and had slowly adjusted to the idea of a groupwork programme.

130. During January, his behaviour deteriorated. A doctor issued him with a repeat prescription for fluoxetine on 11 January. The same day, staff warned him for smoking in the yard. He became aggressive and had to be escorted back to his wing. On 13 January, his personal officer noted that he talked to some officers but refused to speak to others. He expressed reluctance about completing the ARV course.

131. On 15 January, an officer recorded that his attitude had taken a turn for the worse. He was having temper tantrums, getting into arguments and was sulking when he did not get his own way. He was also refusing to take his medication.

132. On 17 January, a SO recorded that his IEP status had been downgraded from enhanced to standard because of his recent poor behaviour at education classes and the bricklaying course. He had received warnings after being caught smoking in the yard.

133. The SO recalled during interview that he apologised to her for the behaviour that had led to his reduced IEP status. She had assured him that she would soon be able to restore his enhanced IEP status if he behaved himself while he was attending his course. As a standard IEP prisoner, he did not have to move cells. He could still associate with the other prisoners as before and still went to his work and education classes. He told his personal officer that he had had a bad couple of weeks, but would work hard to improve his behaviour and regain his enhanced status.

134. On 19 January, he submitted an application for his mother's new telephone number to be added to his authorised call list. She had recently moved house.

Wednesday 25 January

135. On Wednesday 25 January, the man lost his temper and argued with an officer after the latter had to ask him twice to stop chatting to another prisoner and collect his medication. The officer took him back to his cell. He got angry and told the officer to take his television away. The officer did not confiscate the television but had to put it away for safe keeping after the man placed it outside his cell and went to work.

136. Prisoners' telephone calls are recorded. The investigator was therefore able to listen to the telephone calls the man made to family and friends during the last few days of his life. He telephoned his mother on her new telephone number at 2.00pm that afternoon. He told her that he no longer had a television in his cell because he had argued with an officer and told him to take the television away. He said that he had been too depressed to write to

people. He explained that he had not called her for a while because he had no credit.

137. At 2.30pm, he telephoned a friend. He said that the lack of a television was 'doing his head in'. He said that although he had told the officer to take his television away, he would feel stupid asking for it back.

138. At 2.35pm, he telephoned his former partner. She told him that she had written to him with some news that would upset him. He said that he was having a difficult week. She asked him to stay calm and told him that she loved him but they would both feel better for not being together. He said that he was stressed out, could not handle it anymore and was coming out of prison to nothing. By the end of the conversation, he was crying.

139. Later that day, he collected his television from the officer. The officer told the investigator that the man apologised for losing his temper and they laughed together about the incident. He was not issued with a warning and was not penalised under the IEP scheme.

140. Until now, he had been trusted by the staff on Benbow House and had been given the privileged task of painting the landings. However, because of his recent losses of temper, the officer felt that he had become less reliable and could not be trusted to complete the task without supervision. He wrote in the wing observation book that he should no longer be used for any wing jobs because 'he has had enough chances'. The officer's opinion neither affected the man's IEP status, nor his ability to attend his bricklaying course and associate with other prisoners on the wing.

141. The man telephoned his former partner again at 6.00pm. He told her that he had just punched a hard surface and bruised his knuckles. He said that he kept wanting to kill himself. He also told her that he was going to stop taking his medication. He suggested that he might take an overdose but also mentioned that he was not allowed his medication in possession. He then suggested that he might 'string himself up' from his light fitting with a bedsheet, as he had done before at Exeter. He said that he had told the person in charge of his brick laying course that he was going to kill himself. He was crying during the conversation.

142. The investigator spoke to two teachers, who ran the two separate components of the brick laying course. The first teacher said that the man never spoke to him or the class about any suicidal thoughts. The second teacher clearly recalled one incident when the man made a comment in front of the class. As we have already described, the second teacher addressed the issue at the time and passed his concerns to wing staff. He told the investigator that the incident happened around Christmas time, not in the days immediately before the man died.

143. Another prisoner told the investigator that, in the week before the man died, he had witnessed him running back to his cell crying after he put the telephone down. He could not be specific about the date, but the incident he

reported might well have taken place after he made these telephone calls. However, none of the wing staff the investigator spoke to, including the wing manager and his personal officer, remembered seeing him upset that day.

Thursday 26 January

144. The next day, 26 January, the man received an email from his former partner via the 'Email a prisoner' scheme. She indicated in the email that she wanted no further contact with him as a friend or partner because their last conversation had been very upsetting.

145. The same day, he made an application to see a nurse as he felt unwell. He went to the healthcare department after lunch and saw a nurse, a registered general nurse temporarily employed by an agency. He said that he was feeling low in mood and did not feel like leaving his cell or joining in the usual daily activity on the wing. He did not mention that he had received bad news. The nurse did not recall during interview whether his knuckles were bruised.

146. He told the nurse that he wanted to change his behaviour. She asked him if he was having thoughts of self-harm and he said that he was not, but wanted to get out of his cell more and be more involved in wing life. She noted that the mental health team were aware of him and that therefore she did not have to make a new referral to them. There were no mental health nurses on duty in Portland that day (due to unforeseen staff absence).

147. At his request, the nurse made the first available appointment for him to see a doctor on Monday 30 January. She intended for a doctor to review his antidepressant medication. She was keen to reassure him that she had taken his concerns seriously, so she showed him the booking on the computer screen and explained that an appointment had been made. She recalled during interview that he thanked her and was polite. She was unable to make an earlier appointment because the doctor had left for the day after a morning shift, the visiting GP only deals with emergency cases on Fridays, and there are no surgeries over the weekend.

148. At 5.45pm, he left a message on his former partner's answer machine. He then rang his family home and spoke to his brothers.

Events leading up to the incident

149. The man telephoned his mother at 2.30pm the following day. He told her that he had cried after speaking to his former partner and had got involved in a fight. He explained that his former partner did not wish to resume their relationship.

150. He telephoned a friend at about 3.00pm. He told him that he had argued with his former partner on the telephone on Wednesday. He said that he had tried to call her but had got no answer. He said that he was stressed out and that prison was 'driving him mental'.

151. There is nothing in any of the records to indicate that he mentioned any particular concerns to officers before he was locked in his cell as usual on Friday evening. When the night staff take over the wing from the day staff, they must perform a roll check, looking through the observation panel to check the presence and safety of each prisoner. Operational Support Grade (OSG) A checked all of the prisoners on Benbow House at about 8.30pm that evening. He told the investigator that there was nothing unusual about the roll check and all the prisoners were safely accounted for.

152. He worked on Benbow House overnight, another OSG worked on Raleigh House and another OSG worked on Drake House. Benbow, Raleigh and Drake Houses constitute one long interconnected building. At night, the gates between the houses are left open and the OSGs are able to move between them to assist their colleagues.

153. From about 10.00pm, two prisoners living opposite each other on Raleigh House started destroying property in their cells and smashed the observation panels in their cell doors. They were left in their cells until the following morning, when larger numbers of day staff could take them to the segregation unit. In the meantime, the other two OSGs monitored the two prisoners until they calmed down. The supervising officers on duty also came to the wing to assist.

154. The noise and disruption continued until about 4.00am and could be heard on neighbouring Benbow House. The two prisoners causing the disruption lived on the first landing of Raleigh House, which, because of the slope of the site, is at the same level as the second landing of Benbow House, where the man lived at the far end.

155. There were no prisoners subject to ACCT self-harm monitoring on Benbow House for the OSG to check that night. He told the investigator that he answered one cell bell during the night. He said that the man did not press his cell bell and he had no cause to check on him.

156. He began the morning roll check in Benbow House at about 6.30am. The roll check is the last task that night staff are required to perform before the day staff take over the running of the wing. The OSG has to open the observation panel, look inside, check the prisoner and make sure they are safe.

157. He started on the first landing. He was halfway around the second landing when he reached the man's cell (2-13) at about 6.40am. He opened the observation panel and could make out a silhouette in the darkness. He switched the light on and saw him suspended in the middle of the cell. He had tied one end of a torn bed sheet to the light fitting in the middle of the ceiling and the other end around his neck.

158. He used his radio to request 'immediate assistance on the Benbow 2s'. It took the other two OSGs about 30 seconds to reach the cell. OSG B had been on the same level at the end of Raleigh House nearest to Benbow.

OSG A told the investigator that he did not have enough time to consider going into the cell on his own before his colleagues arrived.

159. When the two other OSGs reached the man's cell, OSG A was waiting outside. He told them that the man was suspended from the light fitting and that they needed to enter the cell. The other two OSGs both looked into the cell to confirm this and saw a table lying on the floor.

160. OSG C broke the seal on his emergency key pouch and unlocked the cell. All three OSGs entered the cell, moving the table out of the way. OSG A and OSG C supported the man's weight. OSG B cut through the torn bed sheet with OSG C's specially designed knife (which all prison staff are required to carry). Once he had done this, the three OSGs lowered him onto the bed.

161. The acting orderly officer in charge of the prison that night in the absence of a senior officer was in the orderly room when the emergency call from Benbow House came over the radio network. Benbow House is the wing closest to the orderly office. He went straight to the wing and reached the cell at about 6.43am.

162. An officer also responded to the emergency call. When he arrived, he told the investigator that he found the three night patrol OSGs and the orderly officer at the threshold to the cell. He told the investigator that he found the man lying face down on the bed in his cell. He explained during interview that his colleagues were not attending to him and had not yet removed the torn bed sheet from his neck, as they believed that he had died. The body was cold and stiff to the touch, so they had not attempted cardiopulmonary resuscitation (CPR).

163. The officer told the investigator that he felt obligated to attempt chest compressions. He explained that OSG C passed him his knife, which he already had in his hand, to remove the torn bed sheet from the man's neck. (However, the OSG told the investigator that OSG B removed the bed sheet from the neck.) OSG B helped the officer to turn the man over onto his back. The man remained on the bed when the officer began performing chest compressions at 6.45am. OSG B took over after a few minutes and they continued to take turns. (OSG B told the investigator that he began chest compressions.) Neither the officer nor OSG B gave breaths to the man.

164. At 6.45am, the orderly officer radioed the OSG working in the gate to request an emergency ambulance. The OSG contacted the emergency services at 6.46am. Immediately afterwards, at the orderly officer's request, the gate OSG also contacted the duty governor, who in turn telephoned the Governor.

165. OSG C was given an officer's keys to enable him to escort the paramedics from the gate to Benbow House. The ambulance arrived at 7.00am. The paramedics took observations and confirmed that the man had probably been dead for some time. They told the officers to stop chest compressions and pronounced him dead at 7.04am.

166. The man wrote two notes which staff found in his cell. One was addressed to his mother and grand parents, the other to his former partner.

167. The duty governor arrived at the prison at about 7.20am. The Governor arrived at Portland at 7.40am. The safer custody coordinator arrived at Portland at 8.10am. He agreed to identify the man's body. He then reviewed all of the prisoners subject to ACCT self-harm monitoring, including those in the seven day 'post closure' phase.

168. The Head of Safeguarding held a hot debrief meeting in the Governor's boardroom at 8.50am for all of the night staff. This meeting is intended to check how staff are coping and to learn any immediate lessons from the emergency. Staff were offered the support of a member of the care team.

169. The man had nominated his former partner as his next of kin. However, the Governor and one of Portland's two trained family liaison officers (or FLOs) decided to break the news to his mother instead. They read the notes in his cell and thought that this was the most sensible course of action. The FLO had begun a period of annual leave, but had not yet left for her holiday so agreed to fulfil the family liaison role as soon as she was telephoned that morning. The other trained FLO was also on leave and abroad at the time.

170. The Governor and FLO left the prison at about 10.00am, once the man's body had been removed. At 12.30pm they arrived at the address he had provided for his mother, but discovered that she no longer lived there. The Governor telephoned her and obtained her new address. He did not break the news of her son's death over the telephone, but she inevitably realised that something was wrong. They then set off again but unfortunately entered the wrong postcode for the new address into the satellite navigation device. They subsequently obtained the correct postcode from the police.

171. They found it difficult to find the man's mother's new address because it was in a remote area. They said they had to ask for directions several times, and were hampered because of poor mobile phone coverage. They eventually arrived at 2.15pm and broke the news to her. They were also present when she broke the news to her three younger children. The Governor agreed that she could come to the prison and clear his cell herself. They waited with her until a friend arrived to keep her company.

172. During this time, the police arrived to check on the welfare of those involved and make sure that the prison staff had successfully found the house. The man's mother telephoned her parents to break the news, but the FLO and Governor helped her to answer subsequent telephone calls and make arrangements for the grandparents to join their daughter. The FLO asked her if they should contact his father, from whom she was long since estranged, but she asked them not to. They left at 4.20pm.

173. The man's mother told the Governor that one of her son's close friends was also at Portland. He telephoned his staff to check on the young man's welfare. He was subject to ACCT self-harm monitoring and staff had already

moved him to a double cell with another prisoner. The young man wanted to telephone his girlfriend and the Governor told his staff to arrange this.

174. The man's father lives in a different part of the country and found out about his son's death when he checked a social networking website late that night and read a comment.

175. Because the FLO had booked a holiday from Monday 30 January, and the other FLO was abroad, she arranged for a FLO at HMP Dorchester to continue liaising with the man's mother until she returned from leave. The man's mother and grandparents visited Portland on 30 January, went to see his cell and packed up his belongings. They also visited the mortuary to view the body, accompanied by the Governor and the temporary FLO.

176. When the investigator visited Portland to open the Ombudsman's investigation, a prisoner spoke to him briefly on Benbow House. As well as mentioning the occasion when he had witnessed the man's upset after a telephone call, he also thought that he might have heard him moving furniture during the night he took his own life. The prisoner lived in the cell below him. There is no evidence that the prisoner alerted staff to these noises during the night.

177. In accordance with the policy of the National Offender Management Service, Portland contributed towards the cost of the funeral. The management team also bought flowers for the funeral service. Prisoners arranged a collection for the family. The former chaplain at Portland, who had since moved to HMP Dorchester, agreed to hold the funeral service on Wednesday 15 February. Prison staff and a member from the Independent Monitoring Board (IMB) attended on behalf of the prison.

178. On 16 February, a critical incident debrief was held for the staff who dealt with the emergency. Five members of staff attended.

179. After the funeral, the man's mother and the Governor discussed how her son might best be commemorated. The Governor bought a bench made by prisoners at the nearby prison, The Verne, for her to place on the village green where he used to meet his friends as a way of remembering him.

ISSUES

Clinical care

Exeter

180. A clinical reviewer completed a review of the man's clinical care. He makes the following comments about the care he received at Exeter:

> 'He appears to have been a volatile person. At times he seems to have been cooperative, polite and aware that he had a quick temper and at others he was violent, usually harming himself but sometimes other people and property.
>
> 'From the records it appears that he was quite upset in his first few months in Exeter, leading up to the time of his attempted hanging in February 2011. But he was in close contact with healthcare. In the seven months he was in Exeter he saw a GP eleven times, a nurse fourteen times and the consultant psychiatrist four times.
>
> 'Despite a lot of medical input in Exeter, he very nearly succeeded in killing himself there.'

181. The visiting consultant psychiatrist at Exeter reviewed the man twice and subsequently advised prison staff about the best way to manage him. She diagnosed him with traits of histrionic and dissocial personality disorders, by which she meant that he found his emotions hard to deal with. She found no evidence of psychotic symptoms. She thought that he had some residual paranoia resulting from his substance misuse in his early teens. She prescribed him some low dose antipsychotic medication on a short term basis to ease these symptoms.

182. She did not think that it was appropriate for him to be allocated to the secondary care mental health team's caseload. She thought that this would be detrimental to his recovery. She believed that any concerns regarding his behaviour should be managed by the safer custody team using the ACCT self-harm monitoring process. She thought it important that he try to live a normal life on the wings with access to primary care health services. She told the investigator that the mental health team does work with prisoners with more serious personality disorders, but that there was no indication at any time that he had a serious mental health problem or psychotic disorder.

183. The clinical reviewer explains the implications of a personality disorder in his review:

> 'His behaviour had been assessed as being due to a personality disorder. Personality disorders are not seen as mental illness by psychiatrists, but as the manifestation of who the person is and how they see the world. As they are not illnesses, they cannot be treated.

> ‘In saying that Personality Disorders are untreatable [in the original clinical review] I mean that there are no medicines which can be used to treat them. People can learn how they can change their behaviour themselves through psychological means ("talking therapies") but there no medicines which can make the change as there are for depression, psychosis or bipolar disorder.’

Allocation to Portland

184. The man’s father asked the investigator why his son transferred to Portland, when the Prison Service website indicates that this YOI will not accept prisoners who require ‘long term psychiatric treatment’. He pointed out that his son was prescribed an antipsychotic drug (risperidone) at the time of his transfer.

185. The investigator asked the manager of the mental health in-reach team about the information on the Prison Service’s website indicating that prisoners requiring long term psychiatric treatment were not suitable for Portland. He replied by email:

> ‘I don’t know where this statement has come from or who was responsible for it. I agree that it is vague and confusing but it is also incorrect.
>
> ‘We have an established primary and secondary care mental health service for the prison, this includes a clinical psychology service and access to a learning disability service. The secondary care service has a current caseload of 57 patients... this is about 10% of the prison’s population. These are prisoners who have a long term psychiatric treatment requirement and who are receiving long term care from a psychiatric team to an equivalent standard provided in the community. These patients will be referred onto long term community mental health services on release from prison.
>
> ‘If you add into this the primary care caseload which is currently 110… over 30 percent of the prisoners in Portland are receiving some form of ongoing mental health treatment and are registered on a mental health treatment pathway.
>
> I would also say that it is not possible for any prison to say that they do not accept prisoners with ongoing mental health issues. All the evidence suggests that 10 percent of the prison population has a serious mental illness, 60-70 percent have a primary care mental health need and 70 percent have a personality disorder, so there is no way any prison could ever say that they will not accept this need.
>
> ‘So to say that Portland is not suitable for prisoners with a long term psychiatric need is not only misleading but it is also incorrect.’

186. In light of his response, we make the following recommendation:

The Governor of Portland should ensure that the information on the prison's website is amended to reflect accurately healthcare provision at Portland.

187. It is usual for prisoners like the man to move from the local prison where they have been held for their trial after they have been sentenced. He moved to a YOI more suited to his age in an area not too distant from his mother. In the circumstances the allocation to Portland seems reasonable.

188. The man had expressed a preference to move to a prison in the area where his grandparents lived, but his probation officer explained to him that this was not possible as he needed to remain at Exeter at least until he was sentenced. And at the time his mother had not moved to the same region, which was part of the reason for his request. The consultant psychiatrist at Exeter was aware of his proposed transfer and her only proviso was that he be referred to the mental health team at Portland after his arrival.

Portland

189. The clinical reviewer comments in his review about the clinical care offered to the man at Portland:

> 'By contrast, he did not use healthcare at Portland much and it feels as though he was calmer there than he had been in Exeter. He only went to see the doctor on three occasions about minor problems: hay fever, a verucca and impetigo and each time that was the only issue raised, apparently.
>
> 'Overall it feels as though his care [at Portland] lacked supervision and coherence.'

190. After he transferred to Portland, it was three weeks until he met a healthcare assistant attached to the primary care mental health team, who started a new assessment. The clinical reviewer comments in his review:

> 'I am concerned that the psychiatrist's recommendation that the man be referred to mental health services was not followed up when he was transferred at Portland. Seeing a Healthcare Assistant three weeks after his arrival hardly seems to fit the bill, given his history.
>
> 'From what I have read it feels as though the level of mental health expertise available in Exeter was greater than it is in Portland.
>
> '[The NHS Foundation Trust] needs to ensure seamless transfer of patients between prisons and particularly that the experience gained in one place is put into practice in the next.

191. As he suggests, it seems a notable omission that neither another psychiatrist nor a mental health nurse saw the man after he transferred to Portland.

Although they may very well have reached the same conclusions as the psychiatrist, it seems unsatisfactory, given his complex mental health history, that the responsibility for seeing him after his transfer was left to a healthcare assistant. We make the following recommendation:

The Head of Healthcare at Portland should ensure that prisoners referred to the mental health team are initially seen by an appropriately qualified professional depending on the complexity of the case.

192. The healthcare assistant was the only member of staff to treat the man's mental health problems at Portland. He initially declined to complete an assessment with her and he was discharged by the primary care mental health team. However, he resumed contact and, in November and December, he completed some encouraging work with her. The aim of the 'Emotional wellbeing toolkit' was to help him to learn how to manage his mood and feelings.

193. Healthcare assistants complete work with patients who suffer from a low mood. They receive training and are supervised by mental health nurses and the team manager. Although the clinical reviewer is critical of the mental health treatment the man received at Portland, he adds:

> 'The healthcare assistant seems to have done her best, given the limited resources that [were] available to her.

194. The manager of the mental health in-reach team, which operates from Dorchester, visits prisons in the local area, including Portland. He explained to the investigator that, had the healthcare assistant found evidence of a serious mental disorder, she was able to refer the man to the in-reach team for additional help.

195. In December 2011, the healthcare assistant spoke to a doctor about the man's mental health after she had completed an emotional wellbeing session with him. The clinical record shows that the doctor prescribed him fluoxetine the same afternoon, apparently without seeing him herself. The clinical reviewer comments in his review:

> 'When, in December, [the healthcare assistant] felt the man might be depressed, I am disappointed that he had an antidepressant prescribed without any record of him being assessed by a GP.
>
> 'Quite apart from the wisdom & probity of this, my understanding is that the local PCT expects its staff working in prisons to conform to the standards of the Quality & Outcomes Framework (QuOF). Among many other standards, this requires each person diagnosed with depression to have a Psychiatric Health Questionnaire (PHQ 9) asked of them at diagnosis and for it to be repeated four to twelve weeks after the start of antidepressant medication to see if it is working.
>
> 'As it was there seems to have been no follow up at all.

'The PCT should ensure that the standards of QuOF are achieved in its own establishments.

196. We make the following recommendation based on the clinical reviewer's findings:

The Head of Healthcare at Portland should ensure that a doctor meets a patient face to face and completes a psychiatric health questionnaire before prescribing antidepressant medication. The doctor should review the patient using the same questionnaire within 12 weeks to assess the efficacy of the medication.

197. The healthcare assistant unexpectedly was absent because of ill-health after Christmas and did not return to work for a couple of months. Nobody continued the one-to-one sessions that had been ongoing with the man. No further 'Emotional wellbeing' work was completed in January. While we do not place undue emphasis on the importance of these sessions, they did represent the only input he was receiving for his mental health. He seemed to be working well with her and it is unfortunate that a colleague was unable to continue this work. We make the following recommendation:

The Head of Healthcare at Portland should ensure that contingency plans are in place when a member of staff is absent for a prolonged period to ensure continuity of treatment.

198. On Thursday 26 January, the man saw an agency registered general nurse. He told her that his mood was low, that he was not participating in activities and that he wanted to spend more time out of his cell. The nurse knew that he was being treated by the primary care mental health team and was already prescribed fluoxetine. He asked for his antidepressant medication to be reviewed by a doctor.

199. There was neither a GP nor a mental health nurse in the prison that afternoon. The lack of a mental health nurse appears to have been a staffing issue on that particular day. The doctor had already left for the day after holding a surgery. The GP surgery the following day, 27 January, was not an option because the Friday clinic is intended for emergency cases only. There are no GP surgeries scheduled over the weekend (28 and 29 January), so the nurse booked him in for the next available appointment with a GP on Monday 30 January.

200. The nurse asked him if he was having thoughts of self-harm and he denied this. She showed him the appointment screen to reassure him that he would see a doctor and that his low mood would be treated. He thanked her and she thought that he seemed positive when he left the treatment room.

201. With the benefit of hindsight, it would appear that he might have been signalling to staff that he was struggling to cope, and we know from his telephone conversations that he was feeling upset by 28 January. However,

we think that the nurse took reasonable steps to help him based on the evidence available to her at the time. She asked him about self-harm and he denied having any thoughts of this kind. He did not disclose his bad news to the nurse and she told the investigator that his mood and conversation gave her no reason to be especially concerned about him. There was no one with mental health training on duty at the time.

202. Although he reported his low mood, this kind of problem is not unusual in the context of prison life and would not on its own warrant ACCT monitoring. We think it was reasonable for the nurse to schedule a doctor's appointment, as would happen in the community if a patient did not think their antidepressant was proving effective. Even if a doctor had been available to prescribe alternative antidepressant medication on 26 or 27 January, this sort of drug takes time to affect a patient's mood. It would not have altered his mood before he died.

203. It is important not to draw unwarranted conclusions. Neither we nor the clinical reviewer make a direct connection between the lack of access to mental health staff and the man's decision to take his own life. The clinical reviewer comments in response to the family's feedback to the draft clinical review:

> 'When he did ask for his medicines to be reviewed, on the Thursday, the nurse responded appropriately by making him an appointment… the next available one which was the following Monday. It is not possible to say what might have happened if he had been able to see a doctor sooner.'

Assessment, Care in Custody and Teamwork (ACCT)

Lost ACCT document

204. The man made a serious attempt to take his own life at Exeter in February 2011. He nearly died and subsequently spent time in hospital and the prison healthcare centre. He was subject to ACCT self-harm monitoring for the next four months. The ACCT document definitely transferred with him when he moved to Portland, because a PO reviewed ACCT monitoring immediately after he arrived and closed the document with his consent. It should have been safely stored at Portland after closure, but when he died, safer custody staff were unable to find it when they prepared a copy of his prison file for this investigation.

205. This is clearly a matter of concern, because the ACCT document would undoubtedly provide an important insight into the man's state of mind during a critical period, informing both our investigation and the Coroner's inquest. Additionally, his mother expressed particular concerns about her son's time at Exeter and the ACCT record would have helped her to understand events better.

206. However, his mood subsequently appeared to stabilise and he took his own life over seven months after this ACCT document was closed. The loss of the document, while regrettable, has not prevented a proper investigation of the events leading up to his death, but it did mean that information that could have been very important for the prison to consider in managing him, including on any subsequent period of ACCT monitoring was not available. We make the following recommendation:

The Governor of Portland should ensure that all ACCT documents are safely stored and available for review when necessary.

207. Not quite all of the ACCT document was lost. The PO from Portland's safer custody department telephoned staff at Exeter to discuss the man's progress before he transferred. He asked his counterparts to fax pertinent pages of the ACCT document (including the most recent case review) to Portland. These faxed copies are the only parts of the ACCT document that still exist as evidence. The PO told the investigator that he had wanted staff on Grenville House, the induction unit, to prepare for the man's arrival in light of his relatively recent attempt to take his own life. We think this was a good arrangement to support a prisoner transferring on an open ACCT document.

ACCT care maps

208. When the man was subject to his first period of ACCT self-harm monitoring in December 2010 and January 2011 at Exeter, there were repeated references in the document to the need for a mental health assessment before the ACCT plan could be closed. This assessment was added as one of the goals on the care map. (The ACCT care map outlines the problems that the prisoner faces and the measures that will be put in place to try to resolve them.) The status of this goal was recorded as 'ongoing' and no further information was added to the care map to suggest that it had been achieved when that period of ACCT monitoring ended on 7 January. Although a mental health nurse attended the case reviews (a good example of multi-disciplinary working), there is no evidence in his clinical record of a full mental health assessment at that time. Guidance for staff available at the time in Prison Service Order 2700 (concerning suicide prevention and self-harm management) stated:

> 'The ACCT Plan can only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that it is safe to do so, i.e. that the problems that caused the ACCT Plan to be opened have been resolved or reduced, the prisoner is able to cope with any remaining difficulties, they have access to and are making use of at least some positives, e.g. friends, family, counsellor, member of chaplaincy team, hobbies, education/employment, and they know who to contact (and how) should they need support in the future.'

209. After the first period of ACCT self-harm monitoring at Exeter ended, staff scheduled a post closure ACCT review a week later to check on the man's progress. However, there is no evidence in the ACCT document that the review took place.

210. We have not been able to consult the entirety of the ACCT document which recorded the support offered to the man between February and June 2011, because it is missing. However, we think that the immediate decision to end self-harm monitoring when he transferred to Portland from Exeter was contrary to Prison Service guidance.

211. When he arrived in reception, he told the PO that he no longer wanted to be monitored. The PO explained to the investigator that he made the decision to close the ACCT document. (Unfortunately, the last case review which details this decision has since been lost along with the rest of the document.) He said during interview that four months was a very long time for one period of ACCT monitoring and that the man seemed no nearer to achieving the goals on his care map when he arrived at Portland.

212. In fairness to the PO, the care map we have seen (presumably the most recent version at the time of the man's transfer in June) was dated 10 March, and did not seem to have been updated since early in the period of ACCT monitoring. We agree that it was hard to see its value three months later when his circumstances had changed. However, his care map shows three issues against which the status was recorded as 'ongoing'. We consider that it would have been prudent and in line with the PSO guidance to continue ACCT monitoring while the issues on the care map were either fully addressed or the care map was reviewed. Nor does it seem appropriate to have closed an ACCT document so soon after arrival when Portland staff would have known very little about him.

213. When the man's mood deteriorated in September, staff opened another ACCT document. Staff completed the concern and keep safe form, the immediate action plan and the assessment interview that same day. However, when he held the first case review the next day, the PO ended self-harm monitoring. (The case manager was not at work that day so the PO agreed to hold the review. He was joined by an officer.) As a result, the PO never recorded any issues or goals on the care map, instead writing 'not applicable'.

214. The PO told the investigator that the man had been annoyed that the document had even been opened. He felt that he was being punished because he had made a rash comment to the officer which had been taken too seriously. The PO explained to the investigator that the man had been pacing the cell and was 'fuming' that he was now subject to ACCT checks. The PO sought advice from a mental health nurse.

215. While we think that the PO acted wisely in consulting the nurse; the care map is fundamental to the ACCT process. At the very least, the case manager should have recorded what the issues were and whether or how they had been addressed.

216. Prison Service Instruction (PSI) 64/2011, which has replaced PSO 2700, also states that an ACCT document should be closed only after all the care map actions have been completed. We make the following recommendations:

The Governor of Exeter should ensure that post closure reviews are completed after an ACCT plan is closed.

The Governors of Exeter and Portland should ensure that case managers follow the guidance in PSI 64/2011, regularly updating the ACCT care map and only closing an ACCT plan once the actions in the care map have been achieved.

The man's time at Portland

217. The man seemed to have a good rapport with staff on Benbow House. All of the Benbow staff the investigator spoke to agreed that he would sometimes get very angry very quickly, but would also soon calm down and offer an apology. He was considered to be a polite, articulate and well educated prisoner. He seemed to be making progress. He was enjoying his bricklaying course. The staff on his wing expressed their shock to the investigator that he, of all the prisoners on the wing, should have been the one to take his own life.

218. The man had a personal officer. A SO was the wing manager. Both of them told the investigator that the man seemed reluctant to volunteer any information about his family or personal life. Equally, he never disclosed any suicidal thoughts to them. He was sufficiently well thought of by the staff to be given the jobs of cleaning and painting the wing, tasks only allocated to the most trusted prisoners. Although he had previously been identified as a prisoner with extreme views, the SO told the investigator that he never expressed any racist views on the wing.

219. The man's offender supervisor confirmed that he tended not to disclose personal information. She recalled that he did not trust easily, but seemed to become more confident as time went on. He never discussed with her any suicidal thoughts he might have been having. She was aware of his history of mental health problems. She told the investigator that she spoke to the healthcare assistant three or four times about him. She remembered that he could seem quite flat in mood but did not otherwise raise additional concerns. She described him as 'quiet, polite, intense and serious'. She also confirmed that he never expressed any extreme or discriminatory views to her.

Information sharing

220. The apparent triggers for the man's attempt to take his own life in February 2011 and his ultimately successful attempt in January 2012 were the same – bad news about a hoped for relationship. The investigator discovered that none of the interviewees from Benbow House, including the senior officer and his personal officer, were aware of his previous attempt to take his own life at Exeter the year before. This is somewhat surprising given the significance of the event during his time in custody.

221. However, he did little to concern the officers on Benbow House and was only subject to one very brief period of ACCT monitoring after he transferred. His behaviour did not give significant cause for concern, so the officers were not prompted to ask more questions or check his record. The too hasty closure of the ACCT document on the day he transferred to Portland and its subsequent loss meant that staff on Grenville House (the induction unit) barely got a chance to absorb this significant information, still less staff on Benbow House.

222. Even if the staff on Benbow House had known about his previous suicide attempt, it is unlikely that they would have begun ACCT self-harm monitoring in the days before he died because he did not tell the wing staff about his recent bad news.

223. When he received the news that his girlfriend had ended their relationship, shortly before he died, he became upset on the telephone. None of the wing staff appear to have witnessed this incident and he never disclosed his news to them. There is no available evidence to suggest that wing officers had information which would have reasonably prompted another period of ACCT monitoring.

224. Around Christmas time, he made a threat about taking his own life during his education class, but the class teacher told our investigator that he spoke to him outside the classroom at the time. He was not sufficiently concerned to begin ACCT monitoring, but he did inform an officer to pass on to wing staff. We think that the teacher took appropriate steps by consulting him and passing on the information about the remark. However, there is no evidence in the records to show that the information the teacher tried to pass on about the man's comments in bricklaying class a month before his death were ever communicated to the Benbow staff.

225. The teacher regarded the comment as an off-the-cuff remark when he had lost his temper. The man assured him he had no intention to harm himself. We do not think that the incident should acquire too much significance as another month passed before he was found dead.

Cell Sharing Risk Assessment

226. In early January 2011, while the man was subject to his first period of ACCT monitoring at Exeter, he threatened to assault his cellmate. The officer he made the threat to referred the matter to managers, who decided that he should continue to share a cell and did not warrant a high risk cell sharing risk assessment, in large part because he was subject to the ACCT process (and might harm himself if left alone). PSI 09/2011 regarding cell sharing risk assessments (issued after this incident) gives the following advice:

> 'Where a prisoner is assessed as CSRA high risk but is also self-harming, and it is felt appropriate for the prisoner to share a cell to provide a measure of peer support, it will be for managers responsible for the prisoner's care to balance the safety of both prisoners.'

227. Although there is reference to a CSRA in the man's ACCT document, there is no copy of an assessment in his file dating from January 2011 so we are unable to analyse the decision making of managers at Exeter. There is no evidence that his cellmate was asked how he felt about sharing a cell or was informed of the threat against him while they continued to share. We make the following recommendation:

The Governor of Exeter should ensure that staff follow the instructions in PSI 09/2011 when a prisoner subject to ACCT monitoring also threatens his cellmate. Staff should complete a cell sharing risk assessment clearly outlining their analysis of the risk of self-harm and the risk to the cellmate. If the sharing arrangement continues, the cellmate should be informed of the potential risk and a record made of this conversation.

228. After the man's attempt to take his own life in February, there was considerable deliberation amongst staff at Exeter about the need to balance the risk he presented to himself (by moving him to a shared cell) against the risk he posed to others (by putting him in a single cell). The risk to others eventually proved the more persuasive argument because he repeatedly expressed extreme views.

229. He might have made threats at Exeter because he knew that they would prompt staff to move him to a single cell, which was what he wanted. However, wing staff need to take these kinds of threats seriously and must ensure the safety of other prisoners. He had a history of violence so his threats were not unrealistic. Staff at Exeter clearly thought carefully about this and consulted the psychiatrist for her opinion.

230. His cell sharing risk assessments were then reviewed at appropriate intervals. He was assessed as a high risk of harm to potential cellmates before he left Exeter, when he arrived at Portland and six months after his transfer, in December 2011. He was therefore living in a cell on his own when he died. We think that the decision to locate him in a single cell at the time of his death was reasonable. He had made threats against other prisoners, but there was no significant evidence at the time that he presented a risk of harm to himself.

Telephone calls

231. When she spoke to our family liaison officer (FLO), the man's mother expressed concern that she was unable to speak to her son after she moved house at the start of January 2012. She was concerned that her new telephone number was not added to his authorised call list.

232. She explained to our FLO that she called the prison on several occasions because she was worried that her son was getting depressed and that he had no way of contacting her. She said that she asked the prison to approve her new telephone number quickly, but she was told that the relevant department could not do this until he had himself submitted an application.

233. When she spoke to our FLO, the man's mother recalled that she told prison staff on the telephone how important it was that her son was able to speak with her, as his mood could become very low if he did not. She felt that they did not take her concerns seriously enough at the time. We have not seen any records indicating that her concerns were passed on to wing staff.

234. She explained to our FLO that her father telephoned the prison and asked staff to pass a message to her son. He telephoned his grandfather's approved number and explained that he had submitted an application to add his mother's number to his call list, but that the prison had not yet processed the application.

235. The investigator has established that he did not apply for his mother's telephone number to be added to his list of authorised contacts until Thursday 19 January, over two weeks after she moved house. The number was then authorised within five working days and he telephoned his mother on Wednesday 25 January. We are satisfied that there was not an unreasonable delay in authorising the number once an application was made. Although he did not speak to his mother for three weeks during January, he was in touch with her again at the time of his death.

236. There is no information in his prison record about the telephone calls which his mother remembers making to the staff. There is also no evidence of the concerns she recalls raising being passed onto the wing staff. We make the following recommendation:

The Governor of Portland should ensure that any concerns which relatives or visitors raise about a prisoner's risk of self-harm are communicated to wing staff.

The emergency response

237. Although the statements from staff are not wholly identical, an officer was quite clear during interview that after the three OSGs cut the man down from the light fitting, they laid him on the bed face down with the torn bed sheet still tied around his neck. They then seemed to hesitate and stand in the doorway, joined by the orderly officer. The OSGs told the investigator that no time passed between him being cut down from the light fitting and the officer entering and performing chest compressions, but the officer was concerned that nobody was attending to him at the moment he arrived.

238. OSG A told the investigator that he had thought the man was already dead. Indeed, the officer interpreted his colleagues' hesitation to begin resuscitation as reluctance for that reason. All present agreed during interview that he was cold to the touch when they found him and had almost certainly died during the night.

239. We think that the OSGs' hesitation before attempting resuscitation was understandable. CPR is not effective unless undertaken very quickly and

should not be undertaken if there are signs of rigor mortis. The OSGs did not have the benefit of healthcare staff to advise on this.

240. The officer began performing chest compressions because he was uncertain and that must be the right thing to do. He told the investigator that he did not want to regret not taking every possible step to save a life. He believed that the man had almost certainly died but felt obliged to try. This was a matter of individual judgement. When the paramedics arrived, they stopped CPR and pronounced death within minutes.

241. Although we recognise the concerns of the other staff with regard to resuscitation, the way in which the man was cared for immediately after he was cut down was inappropriate. He was lowered onto the bed but then left face down with the torn bed sheet still around his neck (as the officer and OSG A both confirmed). He should have immediately been turned over onto his back and the torn bed sheet removed from his neck to allow for a proper assessment. Our interviews revealed that the prison staff involved believed that they would have been tampering with a crime scene by removing the bedding from his neck. We make the following recommendation:

The Governor of Portland should ensure that all staff understand that preservation of life is the primary consideration at the scene of an emergency.

242. The officer and OSG B performed chest compressions while the man lay on the bed. Although he had almost certainly already died and it is unlikely to have made a difference on this occasion, it is not usually advised during first aid courses to perform chest compressions on a bed, because the softness of the mattress can negate the effectiveness of compressions. The person should usually be moved to a firm surface before chest compressions are attempted.

243. The officer said he considered moving him onto the floor of the cell but thought that there was too little room to manoeuvre. He told the investigator that he was reluctant to move him onto the landing because of what the other prisoners might see or hear. He also thought that he might be 'interfering with the scene' if he moved him. As he had already gone against the consensus of his colleagues by beginning chest compressions, he felt that he would have struggled to convince them that he should be carried onto the landing.

244. When the man died, OSG C had current 'first aid at work' training. OSG B told the investigator that he had not received first aid training at work. Nonetheless, he had accumulated some knowledge over the years and had previously helped to perform chest compressions. OSG A said that his first aid training had expired. The officer said that he had done a lot of first aid training over the years but was unsure if his training was up to date. Portland does not have 24 hour healthcare and it a serious concern that there were no staff on duty with up to date first aid training. It is important that the night staff in particular receive regular training in CPR. We make the following recommendation:

The Governor of Portland should ensure that there are sufficient first aid trained staff on duty at all times and that all staff who work nights have current training in cardiopulmonary resuscitation.

Family Liaison

245. When the man first arrived in prison, he named his partner as his next of kin. He listed his mother on subsequent documents. After he died, the Governor had to decide who he should approach to break the news of his death. He thought it most appropriate to tell the man's mother. He read the two notes that he had left in his cell and realised that his relationship with his partner had ended. In the circumstances, we agree that he made the correct decision to contact the man's mother.

246. Both trained family liaison officers (FLOs) were on leave at the same time when the man died. Fortunately, another FLO lived locally and had not yet left for her holiday. She was telephoned and agreed to go back to work for the day to help the Governor break the news to the man's mother. The FLO then had to leave for her holiday on Monday 30 January, when she sensibly arranged for the FLO from Dorchester to assist in her absence. It was not ideal for the man's mother to have to deal with two different FLOs so soon after his death. A pooled resource with other prisons in the area might be possible to ensure appropriate cover. Essentially, bereaved families need knowledgeable and consistent support. We make the following recommendation:

The Governor of Portland should ensure that trained family liaison officers are available at all times.

247. The support offered to the man's mother by the prison was commendable. The Governor and the prison's FLO stayed at her home for two hours when they broke the news, fielding telephone calls from relatives and offering their support while she broke the news to her three younger children. The family liaison log is extremely well documented. A number of staff attended the funeral to pay their respects. The FLO continued to liaise with the man's mother after the funeral and intends to maintain contact until the inquest is held. The Governor purchased a bench, which he gave to her to help her create an appropriate memorial for her son.

248. When our investigator and family liaison officer met the man's father at his solicitor's office to discuss his concerns, he was very unhappy about the way in which he found out about his son's death. He checked a social networking site at around midnight on 28 January, and read a comment about his son's death. He was understandably very upset that he should have learnt about his son's death in this way and was very concerned that the prison did not notify him. He also complained about the lack of contact that he initially received from our family liaison team.

249. When the Governor and FLO broke the news of the man's death to his mother, she asked them not to contact his father. Prison staff did not want to distress her any further and complied with her wishes. They did not seek the father's contact details and did not find a way of informing him that day. Informing relatives is always difficult when families are separated. We sympathise with the difficulties faced by prison staff on the day of the man's death, but we consider his father should have been informed. As he was some distance away, it would have been appropriate to use prison staff or the local police to break the news to him in person. We make the following recommendation:

The Governor of Portland should ensure that reasonable efforts are made to contact both parents of a prisoner who dies in custody.

250. When we began our investigation, we were told that Portland staff had been treating the man's mother as his next of kin and we were not provided with his father's contact details. On 10 February, his father made contact with our office through a representative from Inquest (an organisation which helps the bereaved relatives of prisoners). On 23 February, our family liaison officer telephoned the man's mother about the investigation. His father's solicitor subsequently got in touch and the investigator and family liaison officer attended a meeting at his solicitor's office on 26 April. We apologise to his father for any delay in contacting him.

Care team support

251. Almost all of the staff we spoke to during the investigation said that they had had access to appropriate support from the prison's care team after the man died. The only exceptions were a nurse and his offender supervisor. The nurse said that she had not had the chance to speak to the care team, presumably because, as agency staff, she had not worked regularly at the YOI since he died.

252. The offender supervisor is a seconded probation officer. She told the investigator that she had spoken to her line manager in the probation service, but did not feel that she had received the same support from the managers at the YOI. She said that she would have appreciated more support.

253. Although the care team rightly focus their efforts on the staff who tackled the emergency and the staff on the wing where the prisoner lived, it is important to remember other staff in prisons have had significant dealings and close relationships with the deceased. This includes staff running education classes, seconded probation staff or nurses. We make the following recommendation:

The Governor of Portland should ensure that arrangements are made so that any member of staff who might be affected by a death in custody receives appropriate support.

CONCLUSION

254. The man made a serious attempt to take his own life when he was at Exeter after receiving bad news. He was subject to a prolonged period of self-harm monitoring. He was assessed by a consultant psychiatrist who did not think that he had a serious mental disorder which required referral to the mental health team. She prescribed a low dose antipsychotic drug to treat residual symptoms of paranoia caused by previous substance misuse.

255. After he transferred to Portland, self-harm monitoring ended immediately after he arrived. While this was too quick, in general, his mood seemed to stabilise and he worked with a healthcare assistant from the mental health team to address his feelings and emotions. However, in January 2012, his mood became changeable. Near the end of the month his partner ended their relationship and he asked to speak to healthcare staff. Two days later, he took his own life.

256. We do not think that any of the staff at Portland could have predicted or prevented his death. There was no significant event which would have prompted them to begin self-harm monitoring. He had made a passing comment to his teacher a month earlier, and had reported his low mood to a nurse, but both members of staff took reasonable and proportionate steps to help him at the time. He did not disclose his feelings to officers on the wing.

257. While it was apparent that he was dead when he was found, the investigation concludes that night staff require better training to deliver CPR. Although his mother received good support from the prison this did not extend to his father, and there is a need to consider both sides of a family in such sad circumstances. He was not on an ACCT document at the time of his death, but we found some deficiencies in ACCT procedures which need to be addressed.

Response from the man's family to the draft report

The man's mother

258. The man's mother contacted our office to respond to our draft report. She thought that Portland staff should accept 'a great deal of blame' for her son's death. She felt 'very strongly' that Portland failed him. She believed that her son was 'shouting out' for help on a number of occasions but was not given the help he needed. She said that she asked the staff at Portland several times in January 2012 if they would add her telephone number to his list of authorised numbers. She said that she made it 'crystal clear' how depressed he could get and she believed that prison staff acted neglectfully by ignoring her. She thought that his application to add her telephone number to his list of authorised numbers must have been mislaid.

259. She thought that it is unacceptable for Portland to have lost his ACCT document after he transferred from Exeter. She was concerned that Exeter does not seem to have any record of her complaints about his treatment there.

260. She thought that the Governor and the FLO from Portland should have already had her new address when they came to break the news of her son's death to her. She said that she had previously given her new address to staff over the telephone and that her son had sent her a visiting order at the new address. She was also disappointed with the amount of contact she had had from the Governor and FLO since the funeral.

The man's maternal grandparents

261. The man's maternal grandparents also wrote to us in response to the draft report. They said that he would not have wanted to take pills because he was a bright, intelligent boy and the tablets made him feel like a 'zombie'. They pointed out that suicidal people often do not disclose their plans for fear of being stopped. They think that it is not enough to comment that the staff could not have foreseen his intentions simply because he never said anything to them. They think that their grandson gave out clear signals of distress, going from a well behaved, helpful, hard-working boy to a sullen and moody young man. They also think that he was let down by the medical profession both inside and outside prison.

262. The grandparents think that the nurse should have referred him to the on-call doctor on 26 January, rather than giving him an appointment on 30 January. They questioned the accounts of the resuscitation effort given by OSG B and the officer, which they feel are contradictory. They praised the proactive attempts by the officer to save their grandson, but they express serious concerns about the response from the other staff at the scene. They think that their daughter has been treated 'shabbily' by prison staff since the funeral.

The man's father

263. The man's father wrote to the Ombudsman through his solicitor. He was not satisfied with either our investigation or the clinical review. He asked us to contact the psychiatrist at Exeter. The investigator has now interviewed the psychiatrist and the additional information she provided has been added to the report. The father also asked for clarification from the clinical reviewer, and we had provided further commentary from him in the 'Issues' section of the report.

264. He asked us to speak again to one of the prisoners. We attempted to telephone the prisoner, but could not make contact after his release. The father asked us to interview all of the other prisoners living on his son's wing when he died. We told him that we were unable to do this but would interview any other prisoners who came forward with information about him. However, no other prisoners have contacted the investigator.

265. He asked the investigator to interview all of the staff at Portland who might have had contact with the missing ACCT document. We declined to do this because of the potential impact on our limited resources. He asked us to confirm when the probation officer visited his son at Portland, and we have added this information to the report.

RECOMMENDATIONS

For the Governor of Portland:

1. The Governor of Portland should ensure that the information on the prison's website is amended to reflect accurately healthcare provision at Portland.

   The Governor of Portland accepted this recommendation and provided the following response:

   'The prison website will be updated following consultation with the healthcare department regarding the current healthcare provision and to ensure that this is reflected appropriately on our website.'

2. The Governor of Portland should ensure that all ACCT documents are safely stored and available for review when necessary.

   The Governor of Portland accepted this recommendation and provided the following response:

   'A Governors Notice to Staff (GNTS) has been produced and communicated to all staff. Staff are now held accountable for any documents they remove from core records in the Offender Management Unit (OMU) by having to sign for their removal and their safe return. This system will provide an assurance that these documents are stored safely.'

3. The Governor of Portland should ensure that any concerns which relatives or visitors raise about a prisoner's risk of self-harm are communicated to wing staff.

   The Governor of Portland accepted this recommendation and provided the following response:

   'Any concerns about prisoners' risk of self-harm, which are brought to our attention, will be communicated to our wing staff. Any call received is logged and a local safer custody form is completed and forwarded to Safer Custody Team & Residential unit. Calls are put through to the Residential Unit, the Safer Custody department & the Duty Governor informed of the content of any call. Any incoming mail received is monitored in accordance with national mail monitoring policy and wing staff informed of any concerns accordingly. Our Resettlement staff manage the 'e mail a prisoner scheme' and will also be monitoring these in accordance with the national mail monitoring policy with wing staff being informed of any concerns.'

4. The Governor of Portland should ensure that all staff understand that preservation of life is the primary consideration at the scene of an emergency.

   The Governor of Portland accepted this recommendation and provided the following response:

   'A Governors Notice to Staff (GNTS) outlining the primary concern to be considered at the scene of an emergency has been issued to all staff in the establishment. Senior Officers have also been briefed to cascade this information to all staff during their weekly meetings. Our Safer Custody Manager also continues to brief staff on this very important issue during his wing training sessions.'

5. The Governor of Portland should ensure that there are sufficient first aid trained staff on duty at all times and that all staff who work nights have current training in cardiopulmonary resuscitation.

   The Governor of Portland accepted this recommendation and provided the following response:

   'This establishment is looking to increase its contingent of first aid trained staff. Training in cardiopulmonary resuscitation (CPR) is part of a three-day first aid course that staff are required to attend before becoming competent. All our night staff will receive training in CPR by December 2012. This is a realistic timescale given the operational constraints that night working places on our staffs' availability to undertake this in depth training.'

6. The Governor of Portland should ensure that trained family liaison officers are available at all times.

   The Governor of Portland accepted this recommendation and provided the following response:

   'The number of staff trained as Family Liaison Officers will be increased. Expressions of interest have been sought from other staff and additional training is scheduled for the week commencing 13 August 2012.'

7. The Governor of Portland should ensure that reasonable efforts are made to contact both parents of a prisoner who dies in custody.

   The Governor of Portland accepted this recommendation and provided the following response:

   'We will ensure that we contact/inform the identified Next of Kin. Every effort will be made to contact both parents when & where appropriate.'

8. The Governor of Portland should ensure that arrangements are made so that any member of staff who might be affected by a death in custody receives appropriate support.

   The Governor of Portland accepted this recommendation and provided the following response:

   'Protocols are already in place to ensure that in the event of a prisoner's Death in Custody any member of staff, either directly or non-directly employed, who may be affected by the death, will receive the appropriate level of Care Team support as necessary.'

   For the Governor of Exeter:

9. The Governor of Exeter should ensure that post closure reviews are completed after an ACCT plan is closed.

   The Governor of Exeter accepted this recommendation and provided the following response:

   'The safer custody team now monitor all ACCT closures and keep a log of post closure reviews and ensure that these are completed on time.'

10. The Governor of Exeter should ensure that staff follow the instructions in PSI 09/2011 when a prisoner subject to ACCT monitoring also threatens his cellmate. Staff should complete a cell sharing risk assessment clearly outlining their analysis of the risk of self-harm and the risk to the cellmate. If the sharing arrangement continues, the cellmate should be informed of the potential risk and a record made of this conversation.

    The Governor of Exeter accepted this recommendation and provided the following response:

    'All managers are now trained in the requirement to complete CSRA review following any actual or threat of violence regardless of this being to a cell mate.'

    For the Governors of Exeter and Portland:

11. The Governors of Exeter and Portland should ensure that case managers follow the guidance in PSI 64/2011, regularly updating the ACCT care map and only closing an ACCT plan once the actions in the care map have been achieved.

    The Governors of Exeter and Portland accepted this recommendation and provided the following response:

    'The Safer Custody Managers have met with all case managers to re-enforce this point. They will continue to raise this matter and monitor compliance as part of their weekly quality assurance reviews.'

For the Head of Healthcare at Portland:

12. The Head of Healthcare at Portland should ensure that prisoners referred to the mental health team are initially seen by an appropriately qualified professional depending on the complexity of the case.

    The Head of Healthcare at Portland accepted this recommendation and provided the following response:

    'Reception screening and information received will signpost the patient to the most appropriate clinician. For any prisoner who develops mental health issues after being received into the establishment referrals can and are made to the Mental Health In-Reach Team (MHIRT) by nursing staff, other staff and also the prisoners themselves are able to self-refer as necessary. Referrals and applications are allocated to members of the MHIRT each week at the weekly Nursing Team meeting.'

13. The Head of Healthcare at Portland should ensure that a doctor meets a patient face to face and completes a psychiatric health questionnaire before prescribing antidepressant medication. The doctor should review the patient using the same questionnaire within 12 weeks to assess the efficacy of the medication.

    The Head of Healthcare at Portland partially accepted this recommendation and provided the following response:

    'Although we may not always be able to meet the full requirement of the recommendation it is worthy of note that the PHQ-9 may be completed by a qualified psychiatric nurse or GP prior to prescribing and within twelve weeks. If the prescription is a continuation of treatment (e.g. for a new transfer) it may be acceptable to continue the prescription until a review is required.'

14. The Head of Healthcare at Portland should ensure that contingency plans are in place when a member of staff is absent for a prolonged period to ensure continuity of treatment.

    The Head of Healthcare at Portland accepted this recommendation and provided the following response:

    'The weekly handover meeting should include patients that are on every mental health team member's caseload and those on long term leave will be reallocated. A contingency plan will be in existence to ensure that when staff are unavailable for a protracted period there is a continuity of treatment for their clients.'