

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Noel Boylan a prisoner at HMP Channings Wood on 17 February 2017

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Noel Boylan was found hanged in his cell at HMP Channings Wood on 16 February 2017. He died in hospital the following day. Mr Boylan was 46 years old. I offer my condolences to Mr Boylan's family and friends.

Mr Boylan was managed under suicide and self-harm prevention measures (known as ACCT) after he cut himself and disclosed that he had been sexually assaulted at HMP Portland. In spite of being interviewed by police, Mr Boylan heard nothing further and was anxious that his allegation was not being investigated.

Although staff identified Mr Boylan's increased risk of suicide and self-harm and started ACCT procedures on a number of occasions, I am concerned about aspects of the management of the procedures which meant staff did not fully understand and address his risks. Staff should also have done more to keep Mr Boylan apprised about the police investigation which so concerned him.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

October 2017

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	13

Summary

Events

1. In 1998, Mr Noel Boylan was convicted of armed robbery and received an indeterminate prison sentence for public protection with a minimum time to serve of four and a half years. He was moved to HMP Channings Wood on 18 August 2016.
2. On 7 January 2017, an officer placed Mr Boylan on suicide and self-harm prevention monitoring (known as ACCT) after he cut his forearms with broken crockery. Mr Boylan said he had cut himself because he had been sexually abused at HMP Portland, and that he wanted to report this to the police. A prison manager passed the allegation to Devon and Cornwall Police, who interviewed him and referred the matter to Dorset Police. A month later, Dorset Police decided not to pursue Mr Boylan's allegation, but there was no record that he was told about this decision.
3. Prison staff stopped ACCT monitoring on 2 February.
4. On the morning of 16 February, Mr Boylan was told that an appointment with a psychiatrist had been postponed until the following day. Another prisoner said that Mr Boylan was upset by this as it conflicted with a visit. Mr Boylan returned to the wing to collect his lunch and a prison manager noticed that he was acting angrily. Mr Boylan said that he was upset that his appointment had been postponed, so the manager decided to restart the ACCT with hourly observations.
5. At around 1.25pm, an officer checked on Mr Boylan but found him hanging from a ligature. The officer called for urgent assistance. Staff arrived and started cardiopulmonary resuscitation. The prison control room immediately called an ambulance and paramedics arrived at 1.42pm. They took Mr Boylan to hospital but he did not recover and he was pronounced dead at 1.45am on 17 February.

Findings

6. Although staff identified Mr Boylan's increased risk of suicide and self-harm and started ACCT procedures, we are concerned about aspects of the management of the procedures. Healthcare staff did not attend the first ACCT case review, few of the case reviews were multidisciplinary, staff did not always check the caremap and the ACCT was closed despite one of the caremap actions not having been completed. We consider that these failings meant that staff did not fully understand and manage the risks with which Mr Boylan presented.
7. During many of the ACCT case reviews, Mr Boylan mentioned his frustration with the speed of the police investigation and that he had not been updated on developments. We are concerned that no one contacted Dorset Police to obtain updates on their investigation.
8. The clinical reviewer considered that healthcare staff appropriately treated Mr Boylan's physical health problems and his substance misuse problems. However, we are concerned that the assessment made by healthcare staff that

Mr Boylan presented a “complex case of self harm” and that his “risk signature” was increasing was not considered during any of Mr Boylan’s ACCT reviews.

9. When the officer found Mr Boylan, he thought that he had called a code blue emergency (which indicates that a prisoner is unconscious or not breathing), but three other members of staff disputed this. While we appreciate that staff responded promptly and the control room called an ambulance immediately, we are concerned that any delay in calling an emergency medical code could have a negative impact in the future.
10. We are also concerned about the length of time that it took the prison’s family liaison officer to contact Mr Boylan’s next of kin after his death and that the prison relied on telephone conversations rather than any personal visits.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:
 - Multidisciplinary case reviews are held, attended by all relevant people involved in a prisoner’s care, with healthcare staff attending all first case reviews.
 - Specific and meaningful ACCT caremap actions are set that are aimed at reducing a prisoner’s risks to themselves and that the actions are reviewed at each case review.
 - ACCTs are not closed until all caremap actions have been completed.
- The Governor and the Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide or self-harm, and the need to record and share this information.
- The Governor should ensure that staff regularly request updates on investigations when serious allegations have been referred to the police and that the prisoner is kept informed.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including calling an emergency code at the earliest opportunity.
- The Governor should ensure that a family liaison officer is appointed as soon as a prisoner dies and they should inform the prisoner’s next of kin of the death in person, in line with national guidance.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator visited Channings Wood on 23 February 2017. He obtained copies of relevant extracts from Mr Boylan's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Boylan's clinical care at the prison.
14. The investigator interviewed 11 members of staff and three prisoners at Channings Wood on 15 and 16 March and 18 and 19 April. The clinical reviewer accompanied the investigator for five of the interviews on 15 March and another of the Ombudsman's investigators accompanied the investigator for the interviews on 18 and 19 April.
15. We informed HM Coroner for Plymouth, Torbay and South Devon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Boylan's partner, his nominated next of kin, and his wife, his legal next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Boylan's partner said that she believed Mr Boylan required greater support after disclosing that he had been sexually assaulted during a previous prison sentence. She also believed that there had been unexplained delays in the police obtaining information from Mr Boylan about the sexual assault.
17. Mr Boylan's wife said that she believed that Mr Boylan should have been monitored more closely as the risks he presented were heightened due to his two previous suicide attempts, the breakdown in their relationship and a lack of progress in his sentence.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
19. Mr Boylan's partner and his wife both received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Channings Wood

20. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds approximately 700 men. While Mr Boylan was at Channings Wood, Dorset NHS University Foundation Trust provided health services at the prison. Since 1 April 2017, Care UK has been commissioned to deliver healthcare and they sub-contract Devon Partnership Trust to provide mental health care. There is nursing cover from 7.30am to 6.00pm on weekdays and from 8.30am to 5.30pm on weekends. Devon Doctors provides an out of hours GP service.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Channings Wood was in October 2016. The Inspectorate noted that the number of incidents of self-harm were far higher than other similar prisons. They found the quality of Assessment, Care in Custody and Teamwork (ACCT) case management documents and risk assessment for prisoners at risk of suicide or self-harm were very poor. Prisoners' intentions to self-harm were too easily dismissed and some ACCT documents were closed prematurely and occasionally without justification. The Inspectorate noted that the availability of new psychoactive substances (NPS) was a significant problem which posed a threat to the safety of prisoners and the stability of the prison.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to August 2016, the IMB reported that the prevalence of NPS made a significant contribution to unpredictable and extremely difficult prisoner behaviour. The IMB also reported that incidences of self-harm and the use of ligatures had increased in the past year. The number of prisoners supported by ACCT arrangements had also increased.

Previous deaths at HMP Channings Wood

23. Mr Boylan's death was the third person to take their own life at Channings Wood since January 2016. We have made previous recommendations about the need for ACCT procedures to be managed in line with national instructions and about the need to use the correct emergency code when responding to a medical emergency.

Assessment, Care in Custody and Teamwork (ACCT)

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
25. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There

should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

26. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm, to self, to others and from others (Safer Custody).

Incentives and Earned Privileges Scheme (IEP)

27. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels, entry, basic, standard and enhanced.

New Psychoactive Substances (NPS)

28. NPS are an increasing problem across the prison and immigration detention estates. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Psychological effects can include psychosis and hallucinations, depression and suicidal thoughts, antisocial or paranoid behaviour and emotional and erratic behaviour.
29. As well as emerging evidence of dangers to both physical and mental health, there are other links to suicide or self-harm. Trading in these substances, while in custodial settings, can lead to debt, violence and intimidation.
30. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Indeterminate Sentence for Public Protection

31. The indeterminate sentence for public protection was created by the Criminal Justice Act 2003, but abolished in 2012. It was intended for prisoners whose offending was considered dangerous, but not so dangerous that they qualified for a life sentence. Prisoners serve a minimum term of imprisonment, after which the offender can be considered for release if they can satisfy the Parole Board that their risk of reoffending has sufficiently reduced.

Key Events

32. On 6 October 1998, Mr Noel Boylan was convicted of armed robbery and received an indeterminate prison sentence for public protection with a minimum time to serve of four years and six months. Mr Boylan was released from prison on licence on 26 October 2004, but was recalled on 5 January 2006 after he was arrested for drink driving and failed to report for bail. On 30 November 2006, Mr Boylan was released on licence again but was recalled on 21 August 2012 after he was arrested for actual bodily harm against his partner at the time and he then absconded. He spent time at a number of prisons before he was transferred to HMP Channings Wood on 18 August 2016.
33. Prior to arriving at Channings Wood, healthcare staff at HMP Leyhill diagnosed Mr Boylan with general anxiety disorder and depression, which they treated intermittently with mirtazapine and amitriptyline (both antidepressants), and diazepam and pregabalin (both anxiety medication).
34. On 1 November, Mr Boylan applied for support from the substance misuse service (SMS), after he was found to have taken new psychoactive substances (NPS) during a mandatory drug test on 18 October. However despite seeing a substance misuse support worker on 2 November and attending one substance misuse focus group on 10 November, Mr Boylan refused to engage further with the SMS. He said that he had only used NPS to “out” a drug dealer on the wing.
35. In mid November, Mr Boylan told healthcare staff that he had back and leg pain, and problems urinating. Healthcare staff referred him for a Magnetic Resonance Imaging (MRI) scan, which was normal, and hospital staff told Mr Boylan his pain was musculoskeletal. Healthcare staff gave Mr Boylan ibuprofen to treat the pain.
36. During the afternoon of 20 November, Mr Boylan told an officer he had taken an overdose of paracetamol. The officer began Prison Service suicide and self-harm monitoring (known as ACCT) and sent Mr Boylan to hospital.
37. Between 21 and 28 November, staff held five ACCT case reviews and assessed that Mr Boylan’s risk of suicide or self-harm varied between raised and low (on a scale of low, raised and high). Mr Boylan said that he was “self-medicating” due to his back pain and that he did not want to harm himself. Only two of the case reviews were multidisciplinary and a member of healthcare staff only attended the final review. A Supervising Officer (SO) did not complete a caremap for Mr Boylan (designed to identify the main areas of concern and the actions required to reduce risk) and wrote “No caremap objectives as this is all around his back/ pain/ meds/ hospital”.
38. On 2 and 7 December, staff reopened Mr Boylan’s ACCT as he said that he was not eating or drinking. Between 3 and 12 December, staff held four ACCT case reviews and assessed that his risk of suicide or self-harm varied between raised and low. Initially, Mr Boylan said that he was not eating because he was not hungry but then said that it was because staff had treated his back pain poorly. Only two of the case reviews were multidisciplinary and a member of healthcare staff only attended the second review.

39. On 19 December, a SO completed Mr Boylan's ACCT post closure review. On the form, the SO circled yes for the questions "Further interview required?" and "Other Action: Re-open ACCT?". However, there is no record that staff re-opened the ACCT or completed another post closure interview.
40. During the morning of 5 January 2017, an officer suspected that Mr Boylan was under the influence of NPS, so called for healthcare assistance, referred him to the Incentive and Earned Privilege review board and placed him on report. Mr Boylan refused assistance from a healthcare assistant.
41. Later that day, Mr Boylan told the IEP board that he lit a cigarette for another prisoner and that it had been laced with "Spice". The IEP board downgraded Mr Boylan to the basic regime. On 6 January, at Mr Boylan's adjudication hearing, he said that his drink had been "spiked" with NPS and he had not intentionally taken them. The adjudicator adjourned the hearing for further evidence but did not reconvene it before Mr Boylan's death.
42. On the same day, a worker from SMS saw Mr Boylan, who said he needed help with his substance misuse. She created a safety plan for Mr Boylan to increase his awareness of the risks from using illicit substances.
43. At 4.45pm on 7 January, an officer started ACCT arrangements again after Mr Boylan cut his forearms with broken crockery and said that he would attempt suicide. After initially refusing any treatment, Mr Boylan let healthcare staff clean, glue and dress his wounds.
44. Later that day, a SO completed an immediate action plan. He decided that staff should observe Mr Boylan on an hourly basis.
45. An officer then assessed Mr Boylan as part of the ACCT procedures. Mr Boylan said that he had suffered abuse in the past from someone in a position of authority. He also said that he felt scared and did not trust prison staff. The officer suggested that Mr Boylan needed a mental health review, a healthcare review about his medication and to complete a cognitive self-change programme.
46. Later that evening, the night manager spoke to Mr Boylan about why he had self-harmed. Mr Boylan told him that two prison officers had sexually abused him while in HMP Portland between 1988 and 1990, and that he wanted to report this to the police. The night manager then completed a Police Crime Report, which contained brief details of Mr Boylan's allegation, and emailed it to Devon and Cornwall Police, the police liaison officer and the duty governor. He told Mr Boylan that he had contacted the police and that they would be in contact with him soon.
47. On 8 January, a custodial manager held the first ACCT case review with Mr Boylan, a SO and an officer. No healthcare staff attended the review. The SO recorded, on behalf of the custodial manager, that Mr Boylan felt low and that the cuts he had made to his arms were to relieve stress rather than a bid to take his life. Mr Boylan said that, as the police knew about the allegation of sexual assault, the matter was moving forward. The custodial manager considered that Mr Boylan was at a raised risk of suicide or self-harm and decided that

- observations should continue on an hourly basis. He scheduled the next ACCT case review for 13 January.
48. The SO also completed Mr Boylan's caremap and decided that Mr Boylan should speak with mental health staff and should be seen by a doctor for a medication review.
 49. During the afternoon of 9 January, a mental health nurse saw Mr Boylan for a mental health assessment. He told her that he "never felt so low" and wanted to talk to the police about his allegation of sexual assault. Mr Boylan threatened to commit more acts of self-harm if the police did not see him. This information was disclosed to the Head of Safety.
 50. At 7.10pm on 9 January, Mr Boylan rang his cell bell and handed a letter to an officer, which said he had taken a drugs overdose. The officer contacted the night manager, who sent Mr Boylan to hospital.
 51. The following day, a senior mental health practitioner from the hospital saw Mr Boylan. Mr Boylan said that he had been suicidal since reporting the allegation of abuse and that he would attempt to end his life by any means if he returned to Channings Wood. The practitioner noted some evidence that Mr Boylan was suffering with post-traumatic stress disorder.
 52. At 11.40am on 10 January, the hospital discharged Mr Boylan back to Channings Wood. At 12.00pm, the night manager held an ACCT case review with Mr Boylan, a mental health nurse and a prison manager. He recorded that Mr Boylan's mood was changeable and he had had a bad time dealing with the allegations disclosed to the police. Mr Boylan said he wanted to remain on normal location and that he had good relationships with his peers. He considered that Mr Boylan was still at a raised risk of suicide or self-harm and decided that observations should take place on an hourly basis. He recorded that he reviewed the caremap but did not record any new actions. He scheduled the next ACCT case review for 11 January.
 53. During that afternoon, a mental health triage meeting took place involving two nurses and other healthcare staff. They considered that Mr Boylan presented "a complex case of self harm" but as there was no evidence of him having a severe mental illness, he could be managed via the ACCT process. There was no record that this information was considered in a subsequent ACCT review.
 54. On 11 January, the night manager held an ACCT case review with Mr Boylan, a nurse and a SO. He recorded that Mr Boylan was in a much better mood and was making plans to return to work. He had good eye contact and was much more engaging and positive. He considered that Mr Boylan was now at low risk of suicide or self-harm. He decided that staff should have three conversations with Mr Boylan during the day and observe him on an hourly basis during the night. He recorded that he reviewed the caremap but did not add any new actions. He scheduled the next ACCT case review for 16 January.
 55. During the morning of 12 January, a Detective Constable (DC) from Devon and Cornwall Police interviewed Mr Boylan about his historic sexual abuse allegation and completed a First Response Booklet Investigation of Rape and Serious

Sexual Offences. As Portland falls within Dorset Police's jurisdiction, the case was referred to them to investigate.

56. On 16 January, a SO held an ACCT case review with a nurse. Mr Boylan refused to attend the case review, though he told her that he had stopped eating and drinking, that his healthcare appointment had been postponed until 18 January and that he was unhappy being on the basic incentive and earned privilege (IEP) level. She considered that Mr Boylan remained at low risk of suicide or self-harm and that the level of observations should not change. She recorded that she reviewed the caremap but did not add any new actions. She scheduled the next ACCT case review for 19 January.
57. On 18 January, a prison GP saw Mr Boylan for a review. Mr Boylan said he had a constant ache from his back but that was "not the issue". He told her about the allegation of sexual abuse and described having flashbacks of the events. She diagnosed him with post-traumatic stress disorder and prescribed quetiapine (an anti-depressant). She asked the mental health team to refer Mr Boylan for a review with a consultant psychiatrist.
58. On 19 January, a SO held an ACCT case review with the night manager and a member of the chaplaincy team. Mr Boylan refused to attend the case review though he did speak to the night manager on a one-to-one basis. The night manager said that Mr Boylan was unhappy that he had faced an IEP review after using NPS. The SO considered that Mr Boylan remained at low risk of suicide or self-harm and that the level of observations should not change. The SO recorded that he reviewed the caremap but did not add any new actions. The SO scheduled the next ACCT case review for 26 January.
59. Three days later, Mr Boylan's oral parole hearing, scheduled for 2 February, was deferred because his Offender Supervisor was unable to attend. There was no record that the hearing was rescheduled before his death.
60. On 25 January, the prison GP saw Mr Boylan again and noted he was struggling with his movement due to his back pain. Mr Boylan said that he did not think that the quetiapine was working, though he felt more relaxed despite waiting on a further police interview. She discussed coping strategies with Mr Boylan to stop him self-harming and prescribed zopiclone (a sedative) to help him sleep.
61. On the same day, Mr Boylan formally complained about his IEP status, as he said that his drink had been "spiked". A prison manager responded and explained that no additional evidence supported his claim. In spite of this, the following day, Mr Boylan's IEP status was raised to standard.
62. On 26 January, a SO held an ACCT case review with Mr Boylan, a mental health nurse and a member of chaplaincy. The SO recorded that Mr Boylan was more positive and looking forward to his life outside prison, though he was still waiting for an interview with the police. The SO recorded that Mr Boylan's medication issues had been resolved, though he did not review the caremap. The SO considered that Mr Boylan remained at low risk of suicide or self-harm and that the level of observations should not change. The SO scheduled the next ACCT case review for 2 February.

63. On 31 January, a mental health triage meeting took place involving a nurse, a mental health nurse and other healthcare staff. After reviewing Mr Boylan's ACCT notes, they considered that his "risk signature" was increasing and that he required care management via the ACCT process. They arranged for Mr Boylan to see a consultant psychiatrist on 16 February. There was no record that this information was considered in a subsequent ACCT review.
64. On 2 February, a SO held an ACCT case review with Mr Boylan. No one else attended. The SO recorded that Mr Boylan was more settled on the wing and was waiting to hear from the police about his sexual abuse allegation. The SO considered that Mr Boylan remained at low risk of suicide or self-harm and. He decided that staff should have two conversations with Mr Boylan during the day and they should observe him four times during the night. The SO did not record that he reviewed the caremap. The SO decided to end the ACCT arrangements and he scheduled a post closure review for 9 February.
65. On 6 February, a clerk in the offender management unit took a call from Mr Boylan's wife, who had decided that Mr Boylan could contact her and their children again. Mr Boylan made six telephone calls to his wife before he died.
66. On 9 February, a SO held an ACCT post closure interview with Mr Boylan. He recorded that Mr Boylan was not happy, as he was still waiting to see the police. Mr Boylan told him he had support from his partner, staff and other prisoners. The SO decided that a further interview was required, but he did not record a date for the next interview or the reason for it. The night manager later confirmed that the second interview was due to take place on 17 February.
67. On the same day, Dorset Police decided not to pursue Mr Boylan's allegation because it amounted to battery, as the alleged assault happened while the prison officers were searching for drugs, and prosecutions for battery generally had to be laid within six months. There was no record that this decision was passed to Mr Boylan or to anyone in Channings Wood before his death.
68. On 13 February, Mr Boylan made a formal complaint about the handling of his sexual abuse allegation. He wrote that the police had visited him for 15 minutes but he had not received any further information. Mr Boylan wrote that he would like to see the police and asked what further support he could receive. He wrote that it was "making me feel like I wished I never spoke out". Staff did not respond to Mr Boylan's complaint before he died.
69. During the evening of 14 February, Mr Boylan telephoned his partner. The investigator listened to the call and they discussed her prison visit later that week and his complaint to the police. Mr Boylan told her he had made a formal complaint about the handling of his sexual abuse allegation.

Events from 16 February 2017

70. During the morning of 16 February, Mr Boylan attended the healthcare centre for the appointment with a psychiatrist. While waiting to be seen, a member of the healthcare administration team told Mr Boylan that his appointment had been postponed until the next day. At interview, a prisoner who was in the healthcare centre at the same time said that the member of staff was quite dismissive when

she spoke to Mr Boylan. He said that Mr Boylan was quite upset by the postponement as it would conflict with the visit from his partner. When he returned to the wing, he asked a member of staff whether Mr Boylan was okay but did not raise his concerns as he expected to speak to Mr Boylan after lunch. The Head of Healthcare was unable to identify the member of staff who told Mr Boylan his appointment was postponed.

71. At around midday, Mr Boylan went to the wing servery to collect his lunch. A manager and an officer were at the servery and they described Mr Boylan as acting angrily and shouting at the servery staff. The manager spoke to Mr Boylan to find out what was wrong, and he said that he wanted to be transferred from the prison. As Mr Boylan continued to shout, he took him to the wing office to discuss what had upset him. Once in the wing office, Mr Boylan apologised for his behaviour but explained that he was upset that his psychiatrist appointment had been postponed and he did not want it to affect a visit from his partner. As he was upset, the manager asked Mr Boylan whether he had any thoughts of self-harm but Mr Boylan said he did not. In spite of this, the manager decided to restart the ACCT so that staff could support Mr Boylan.
72. At 12.30pm, the manager recorded in the ACCT observation record that he had reopened Mr Boylan's ACCT because of his low mood. He planned an ACCT case review for after the lunchtime meal and decided that staff should observe Mr Boylan on an hourly basis until the review.
73. At around 1.25pm, an officer went to Mr Boylan's cell to check on him. He looked into Mr Boylan's cell and saw him hanging from a ligature, made from a belt, attached to the window at the back of the cell. He used his radio to call for urgent staff assistance. He then went into Mr Boylan's cell, cut the ligature and lowered him to the floor. Staff responded to the radio message and started cardiopulmonary resuscitation (CPR). A defibrillator (a life saving device that gives the heart an electric shock to restart the heart rhythm in some cases of cardiac arrest) was attached to Mr Boylan, but it did not detect a shockable heart rhythm and advised to continue CPR. A prison GP also inserted an airway down Mr Boylan's throat and gave him a dose of adrenalin.
74. The prison control room received the call for urgent assistance at 1.29pm and immediately telephoned for an ambulance. Paramedics arrived at 1.42pm and an air ambulance arrived ten minutes later. They took over Mr Boylan's care and the air ambulance took Mr Boylan to hospital at 2.44pm. The Head of the Offender Management Unit authorised two officers to accompany Mr Boylan to hospital but that they should not restrain him.
75. At 6.30pm, hospital staff moved Mr Boylan to the critical care unit where he remained in an induced coma and on life support. At around 8.10pm, Mr Boylan's partner visited him in hospital.
76. Mr Boylan's condition continued to deteriorate and a hospital doctor pronounced that he had died at 1.45am on 17 February.

Contact with Mr Boylan's next of kin and family

77. At around 4.30pm on 16 February, a chaplain contacted Mr Boylan's partner, his nominated next of kin, and his wife to tell them that he had been admitted to hospital. The hospital informed Mr Boylan's partner and wife that he had died.
78. On the evening of Mr Boylan's death, the prison appointed an officer as a family liaison officer. The following day, she contacted Mr Boylan's wife to offer her condolences and support, and tried to do the same with his partner. Two days later, she spoke to Mr Boylan's partner and offered her condolences and support. She continued to support Mr Boylan's partner and wife.
79. Mr Boylan's funeral took place on 10 March and the prison contributed to the costs, in line with national guidance.

Support for prisoners and staff

80. After Mr Boylan's death, a manager debriefed the staff involved in the emergency response and offered support. At the time of Mr Boylan's death, the prison did not have a care team to offer staff support.
81. On morning of 17 February, the Governor issued notices to staff and prisoners informing them of Mr Boylan's death. Officers and members of the chaplaincy team supported prisoners. Staff reviewed all prisoners who had been assessed as at risk of suicide and self-harm, in case they were adversely affected by Mr Boylan's death

Post-mortem report

82. The post-mortem examination found the cause of death to be hypoxic ischaemic encephalopathy (a condition that occurs when the entire brain is deprived of an adequate oxygen supply) caused by ligature suspension.
83. A toxicology report found a therapeutic level of quetiapine and other life saving drugs in Mr Boylan's blood, though there was no evidence of any other drugs, including NPS. However, the forensic toxicologist stated that there is some information to indicate that many, especially current, synthetic cannabinoids may be unstable in blood or urine and may be rapidly eliminated from the body. As a result, the forensic toxicologist was unable to entirely exclude the use of synthetic cannabinoids prior to death.

Findings

Assessment of Mr Boylan's risk of suicide or self-harm

84. PSI 64/2011 sets out the processes that should be followed when an ACCT is opened. These include that the first ACCT review must involve a member of healthcare, that subsequent case reviews must be multidisciplinary where possible, that the caremap should be considered during case reviews and that an ACCT should only be closed once all caremap actions have been completed.
85. In respect of Mr Boylan's first ACCT review, which took place on Sunday 8 January, no one from healthcare attended and there was no record that they had been invited or the reasons why they could not attend. During an interview with the Head of Safety, he confirmed that a limited number of healthcare staff work in the prison on a Sunday and that the requirement to hold the review within 24 hours of the ACCT being opened may account for why no healthcare staff attended the review. While we appreciate that the first ACCT review met these timescales, we note from Mr Boylan's medical record that a nurse and a healthcare assistant were working at Channings Wood on 8 January. As the ACCT review took place 23 hours after an officer opened the ACCT, we consider that there was ample time to plan for a member of healthcare to attend the review.
86. Despite a SO creating caremap actions that required healthcare input to address Mr Boylan's mental health issues and his back pain, healthcare staff only attended three of the seven ACCT case reviews (on 10, 11 and 26 January). Additionally, only the SO and Mr Boylan attended the final ACCT review on 2 February. We are concerned that by failing to consistently make Mr Boylan's case reviews multidisciplinary, staff were unable to properly assess his risk of suicide or self-harm. We are also concerned that many of the ACCT case reviews held between 21 November and 12 December were not multidisciplinary.
87. Healthcare staff discussed Mr Boylan's mental health during triage meetings on 10 and 31 January, deciding that he presented a "complex case of self harm" and that his "risk signature" was increasing. However, there was no record that this information was considered during any of Mr Boylan's ACCT reviews. We are concerned that this information, particularly the comment about the increase in his risk, was not considered and that Mr Boylan's ACCT was closed despite these concerns.
88. With regard to the caremap, the SO did not record that he had reviewed it during the ACCT reviews held on 26 January and 2 February. He also decided to close Mr Boylan's ACCT despite one of the actions on the caremap not having been completed. We are also concerned that in respect of Mr Boylan's ACCT in November, the SO did not complete a caremap, despite his issues having centred around treatment for his back pain.
89. We make the following recommendations:

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

- **Multidisciplinary case reviews are held, attended by all relevant people involved in a prisoner's care, with healthcare staff attending all first case reviews.**
- **Specific and meaningful ACCT caremap actions are set that are aimed at reducing a prisoner's risks to themselves and that the actions are reviewed at each case review.**
- **ACCTs are not closed until all caremap actions have been completed.**

The Governor and the Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide or self-harm, and the need to record and share this information.

Police liaison

90. Mr Boylan first alleged that prison officers at Portland had sexually assaulted him on 7 January 2017. Despite being interviewed by a DC five days later, Mr Boylan regularly expressed concerns that the police were not progressing the matter. Mr Boylan raised these concerns during ACCT reviews on 26 January and 2 February, during an ACCT post closure interview on 9 February and in a formal complaint made on 13 February.
91. Despite these concerns contributing to Mr Boylan's risk of suicide and self-harm, there was no record that anyone contacted Dorset Police to obtain updates on their investigation. Additionally, we are concerned that when Dorset Police decided not to pursue the allegations, they failed to inform Mr Boylan.
92. While we cannot be sure whether knowledge of how Dorset Police's investigation had progressed would have changed the outcome for Mr Boylan, it is possible that it would have changed his opinion of staff at Channings Wood and helped him recognise that they were willing to help him. This may have improved Mr Boylan's engagement in the ACCT process. We make the following recommendation:

The Governor should ensure that staff regularly request updates on investigations when serious allegations have been referred to the police and that the prisoner is kept informed.

Clinical care

93. The clinical reviewer considered that the care that healthcare staff provided in relation to Mr Boylan's back problems was appropriate and that there was little else that they could have done.
94. In relation to Mr Boylan's suspected use of NPS, the clinical reviewer noted that the prison's substance misuse service (SMS) had seen him in November 2016 and January 2017. After initially engaging with the SMS, Mr Boylan declined further appointments with them. We agree with the clinical reviewer that it was appropriate for the SMS not to arrange further appointments, as help with drug abuse is only possible if the patient is willing to engage, which Mr Boylan was not prepared to do.

95. In relation to Mr Boylan's mental health issues, the clinical reviewer considered that there was a potential delay in arranging an appointment with a consultant psychiatrist. The psychiatrist had noted some evidence that Mr Boylan was suffering with post-traumatic stress disorder on 10 January, which a prison GP formally diagnosed eight days later, yet the appointment with the consultant psychiatrist was not arranged until 16 February. While there was a delay, the clinical reviewer noted that the GP had reviewed Mr Boylan on two occasions during this period and that this level of care was at least as good as he would have received in the community.

Emergency response

96. Prison Service Instruction (PSI) 03/2013 'Medical Emergency Response Codes', contains a mandatory instruction that prison staff should use a code blue for any emergency where a prisoner is unresponsive, has symptoms including chest pain and difficulty in breathing and that they should not delay summoning emergency assistance.
97. During the interview with an officer he said that he called for urgent staff assistance and thought that he had called a code blue emergency (which indicates that a prisoner is unconscious or not breathing). However, the statements from a nurse, another officer and the SO dispute that the officer had called a code blue.
98. The nurse said that no code blue was called during the first radio transmission and the location of the incident was unclear, while another officer and the SO both said that they only heard a call for urgent medical assistance.
99. In spite of a code blue not having been called, we appreciate that prison and healthcare staff responded promptly and the control room immediately called an ambulance. Therefore, we do not consider that the officer's lapse affected the outcome for Mr Boylan. Nevertheless, failing to call a code blue in a similar situation in the future could result in a delay that could be critical in terms of saving a prisoner's life. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including calling an emergency code at the earliest opportunity.

Family liaison

100. PSI 64/2011 sets out the processes that prisons should follow for informing families after a death in custody. This includes that prisons must promptly notify the prisoner's next of kin about their death and that, where possible, contact should be made in person.
101. Mr Boylan died at 1.45am on 17 February, yet the prison did not appoint the family liaison officer until that evening, and she did not attempt to make contact with his partner or wife until around 2.00pm on 18 February. While Mr Boylan's partner and wife were aware that he had died, we are concerned that this delay limited the support that the prison was able to offer.

102. We are also concerned that the family liaison officer did not consider visiting Mr Boylan's partner or wife in person, despite them living around two hours from the prison. She also did not consider requesting the assistance of a family liaison officer at a local prison to visit Mr Boylan's partner (Channings Wood was the closest prison to Mr Boylan's wife). We make the following recommendation:

The Governor should ensure that a family liaison officer is appointed as soon as a prisoner dies and they should inform the prisoner's next of kin of the death in person, in line with national guidance.

Staff support

103. At the time of Mr Boylan's death, the prison did not have a formal care team who were able to offer staff support following a traumatic incident. This meant that the prison could not comply with PSI 08/2010, Post Incident Care, which highlights the actions that must be followed by prison management following traumatic events to meet their duty of care to staff.
104. However, in response to a recommendation made in another of our investigations, Channings Wood has subsequently introduced a formal care team so we make no recommendation.

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