Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bradleigh Barnes, a prisoner at HMP Portland, on 28 December 2019

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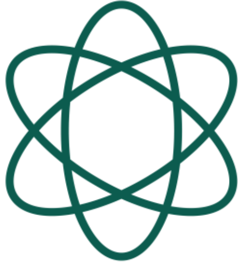
Our vision

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

OGL

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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.

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

Mr Bradleigh Barnes died on 28 December 2019 at HMP Portland from hanging. He was 23 years old. I offer my condolences to Mr Barnes's family and friends.

This report is very late due to unavoidable delays as a result of the COVID-19 pandemic. I am very sorry for the additional distress caused to the family by these delays.

I am concerned about a number of aspects of the care offered to Mr Barnes, all of which echoed concerns raised by Her Majesty's Chief Inspector of Prisons during an inspection in July and August 2019 and concerns raised by the Independent Monitoring Board both in their latest report and directly with my investigator.

Of greatest concern was the inadequacy of the mental health service and the clinical reviewer concluded that the care offered to Mr Barnes was not equivalent to that which he would have expected to receive in the community. There were also deficiencies in suicide and self-harm monitoring and use of force procedures. We make a number of recommendations, including a high-level recommendation to address the issues about healthcare services.

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

Sue McAllister CB
Prisons and Probation Ombudsman **December 2021**

Contents

Summary 1

The Investigation Process 5

Background Information 6

Key Events 8

Findings 17

Summary

Events

1. Mr Bradleigh Barnes had a history of substance misuse, self-harm by cutting, depression and anxiety. He had served a number of short sentences in young offender institutions and prison since 2012. In May 2017, he was sentenced to three years and five months in prison for robbery.

2. Mr Barnes was released on licence on 5 June 2019 and recalled to prison for the rest of his sentence on 20 June. On 12 July, he transferred to HMP Portland.

3. Mr Barnes worked well with substance misuse services and got a job in the prison's bicycle maintenance workshop. He was due for a parole hearing in January 2020 and his probation officer had arranged for him to work in his local Halfords store in the community.

4. On 27 November, Mr Barnes referred himself to the prison's mental health team. The same day, the security department informed healthcare staff that Mr Barnes was hearing voices and had not slept for three days. On 3 December, the mental health team triaged Mr Barnes's case as non-urgent. The target for assessment of non-urgent referrals was five days but Mr Barnes was not assessed before he died.

5. On 23 December, Mr Barnes barricaded his door and was reported to be behaving "bizarrely". Prison Service suicide and self-harm procedures (ACCT) were started, and he was removed, using force, to a safer cell. When staff removed him from the barricaded cell, Mr Barnes had his dressing gown cord tied around his neck, although he denied this was a ligature.

6. A nurse attended the use of force and decided to refer Mr Barnes for a mental health assessment. She did not see his clinical record before the planned removal and was unaware of his existing referral. Mr Barnes's clinical record was in a different name to his prison record and the nurse referred the wrong prisoner to the mental health team. No member of healthcare staff attended his first ACCT case review, and this error was not picked up until after he died.

7. Mr Barnes pressed his cell bell several times during the afternoon of 28 December, but we have not been able to establish why. He was last seen alive at a check at 4.30pm.

8. At about 8.20pm, an officer found him hanging in his cell. Cardio-pulmonary resuscitation (CPR) was attempted without success. Paramedics arrived and confirmed that Mr Barnes had died.

Findings

9. The process for identifying aliases on the clinical record does not effectively identify prisoners that are known by more than one family name. This led to the wrong prisoner being referred for mental health assessment and prevented a nurse called to see Mr Barnes from reading his medical record in advance.

10. Mr Barnes was triaged as requiring a non-urgent mental health assessment without reference to all available evidence. Opportunities to re-assess him were missed, in part due to the confusion over his name.

11. We identified severe problems with the provision and oversight of the mental health service at HMP Portland including:

    - chronic recruitment and retention issues;
    - very limited service provision;
    - lack of oversight;
    - failure to monitor delays;
    - no effective escalation of problems to the commissioners: and
    - no strategic action to deliver widespread change.

12. Delays for non-urgent mental health assessments were unacceptably long with prisoners waiting about 14 weeks.

13. There were a number of deficiencies in the ACCT process applied to Mr Barnes, including:

    - The assessment did not take place within 24 hours.
    - The assessment and first case review took place at the same time.
    - No one from the healthcare unit attended the first case review.
    - Caremap actions put the onus on Mr Barnes and were not meaningful or aimed at reducing his risk.
    - Some observations were at predictable intervals.
    - There was no evidence of meaningful conversation on the on-going record.

14. Mr Barnes was allowed to decide himself when he moved from the safer cell back to a standard cell and this decision was not reviewed as part of the ACCT process as it should have been.

15. Mandatory use of force paperwork was not completed, and Mr Barnes was not seen by a nurse within 24 hours as he should have been. A culture of non-involvement of healthcare staff in planned uses of force appeared to have developed.

16. Cardiopulmonary resuscitation was attempted without the removal of the ligature and when signs of death were present.

17. The prison’s liaison with the PPO was poor and not all the evidence and material requested was provided.

Recommendations

- The Head of Healthcare should identify prisoners at HMP Portland whose clinical record is in a name different to the one used by the prison and, together with the SystmOne IT lead, should review the process for flagging such patients to ensure that clinical staff are able to identify their records from either name.

- The Head of Mental Health should ensure that all available information is taken into consideration when triaging a prisoner for mental health assessment, in particular:
    - further information should be obtained from the security department where it is indicated that relevant information has been received; and
    - relevant applications by the prisoner should be scanned on to their clinical record.

- The NHS Commissioner should urgently review the mental health service at HMP Portland, with the Governor and Head of Healthcare, and ensure the service specification is met and an effective service is delivered to all prisoners.

- The Governor and the Head of Healthcare should ensure that staff manage prisoners identified as at risk of suicide and self-harm in line with national guidelines including:
    - assessments and first case reviews should take place within 24 hours of the start of ACCT monitoring;
    - assessments and case reviews should be separate;
    - a member of the healthcare team must attend the first case review;
    - all staff visiting the wing should be made aware if the prisoner they are seeing is subject to ACCT monitoring;
    - caremap actions should be specific and meaningful and aimed at reducing the prisoners’ risks to themselves; and
    - ACCT documents should be completed fully and accurately, including following the prescribed level of observations at irregular intervals and recording them.

- The Governor should ensure that the decision to move a prisoner from a safer cell to a standard cell is taken at an ACCT review.

- The Head of Healthcare should ensure that all healthcare staff understand their responsibilities during and after a use of force, as set out in PSO 1600.

- The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman’s findings with her.

- The Governor and Head of Healthcare should ensure that staff are aware that ligatures should be removed before resuscitation is attempted.

- The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

- The Governor should ensure that the prison’s designated liaison officer cooperates fully with all requests from the PPO for information, material or access to establishments and prisoners in line with PSI 58/2010.

The Investigation Process

18. The investigator issued notices to staff and prisoners at HMP Portland informing them of the investigation and asking anyone with relevant information to contact her. One prisoner asked to speak to her and was interviewed.

19. The investigator obtained copies of relevant extracts from Mr Barnes's prison and medical records. The prison sent disks containing CCTV from 23 and 28 December 2019 but she was unable to view the files on them. She watched body-worn camera footage from 23 December.

20. NHS England commissioned a clinical reviewer to review Mr Barnes's clinical care at the prison. The investigator and clinical reviewer interviewed twelve members of staff in May and June 2020. The investigator spoke to a further four staff alone. Due to restrictions in place during the COVID-19 pandemic, all the interviews took place by telephone.

21. We informed HM Coroner for Dorset of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

22. Our family liaison officer wrote to Mr Barnes's next of kin, to explain the investigation and to ask if they had any matters, they wanted the investigation to consider. Mr Barnes's next of kin asked us a number of questions about the events leading up to Mr Barnes's death and the emergency response, which we have answered in this report and in separate correspondence.

23. Given the delay in producing our report, the investigator offered Mr Barnes's next of kin via a video call to go through our findings and answer their questions. We have sent them a copy of this report.

24. Mr Barnes's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

25. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Portland

26. HMP Portland holds up to 530 adult and young adult male prisoners. Mental and physical healthcare is provided by Care UK. Substance misuse services are provided by EDP Drug and Alcohol Services. Primary healthcare is provided every day between 7.30am and 6.00pm and, at the time of writing mental healthcare, is provided Monday to Friday 8.00am to 4.30pm (instead of 8.00am to 6.00pm in the service specification).

HM Inspectorate of Prisons (HMIP)

27. HMIP's most recent full inspection of Portland was in July/August 2019. Inspectors found high levels of violence and self-harm despite an impressive reduction in the use of drugs. Care for most prisoners at risk of self-harm was inconsistent. The quality of most ACCT documents was poor, with cursory comments and gaps in key areas such as care maps and observations. The quality assurance process had failed to address these deficiencies

28. Inspectors also found that the mental health service did not meet the service specification and was not informed by an up-to-date needs assessment. Chronic staff shortages limited treatment options and healthcare recruitment was a significant challenge. Failure to attend appointments was high and reflected many occasions when the prison was unable to facilitate movement to appointments.

29. Use of force was high with inadequate scrutiny. Paperwork was not always comprehensively completed and not all video footage of planned incidents was available to view.

Independent Monitoring Board

30. 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 March 2020, the IMB noted that illicit substances continued to present problems for the prison. Drug-related debt, extortion, violence, self-harm and mental health issues were a constant feature of life in Portland and the number of prisoners asking to self-isolate had increased.

31. Problems with the appointment and retention of mental health and psychology staff and delays in diagnosis and treatments had an impacted negatively on prisoner health and well-being. Prisoners with poor mental health did not feel supported on the wings and there was a lack of psychosocial support.

32. The completion of use of force documentation was still problematic but the safer custody department was driving improvement.

33. A Board member echoed these concerns and told the investigator in January 2020, that the number of prisoners subject to suicide and self-harm monitoring had increased since HMIP's inspection to 35 (in January 2020). She felt the management of these prisoners had improved but staffing levels meant that this

became more difficult as the number of prisoners being monitored increased. In particular, there was additional pressure on individual staff monitoring and supporting ACCT care plans. The standard number of observations tended to be at a low level as a result.

Previous deaths at HMP Portland

34. Mr Barnes's death was the first at Portland since September 2016. In our investigation of the previous death, we made two recommendations about the operation of suicide and self-harm monitoring procedures (known as ACCT) which are repeated in this report.

Assessment, Care in Custody and Teamwork

35. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Licence recall

36. When prisoners are released on licence, they are required to keep to certain conditions while serving the remainder of their sentence in the community. Released prisoners on licence are supervised by probation services.

37. When released, the prisoner is given a copy of their licence with all of the conditions they must follow.

38. If they do not keep to the conditions of their licence, are charged with another crime, or behave in a way that causes their probation officer concern, the licence can be revoked, and the offender recalled to prison. The recall can be for 28 days (known as a fixed term recall) or to serve the remainder of the original sentence (known as a standard recall). Prisoners are given the reasons for their recall and can make written appeals to the Parole Board.

Safer cells

39. Safer cells are specially designed with minimal ligature points to help prevent prisoners hanging themselves.

Key Events

40. Mr Bradleigh Barnes had a history of substance misuse, self-harm by cutting, depression and anxiety. He had served a number of short sentences in young offender institutions and prison since 2012.

41. In May 2017, he was sentenced to three years and five months in prison for robbery and was taken to Portland.

42. In October 2017, he formally changed his name from Bradleigh Maine to Bradleigh Barnes. His medical records remained in his previous name.

43. During his time at Portland, Mr Barnes worked with secondary mental health services and was on the caseload of the visiting psychiatrist. He was known to use psychoactive substances (PS), he sometimes displayed psychotic symptoms after using PS, and he sometimes self-harmed by cutting.

44. From November 2018, he chose to self-isolate (stay in his cell and be separate from other prisoners) and told staff he was under threat because of a large, historic drug debt. (He said that while in the community he had been given drugs worth £4-5,000 to smuggle into a prison but had stolen them and kept them for his own use.) He was also anxious about his release as he feared he or his family would be targeted by the people he owed money to. He was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) from May 2019 until 5 June 2019, when he was released on licence to an Approved Premises (probation hostel).

45. On 20 June 2019, he was recalled to prison for breaching his licence conditions by staying out after curfew.

HMP Exeter

46. Mr Barnes was taken to HMP Exeter on 22 June. Reception staff began ACCT monitoring as a matter of course because he had self-harmed within the previous six weeks. Mr Barnes said he had no current plans to harm himself. He applied for vulnerable prisoner status under Prison Rule 45 because he was anxious about meeting prisoners that he had known in HMP Winchester two years earlier. His ACCT monitoring was reviewed and stopped the next day.

47. On 25 June, ACCT monitoring was started again after Mr Barnes said he felt suicidal on learning that he had been recalled to prison for the rest of his sentence. Mr Barnes also raised concerns about transferring to HMP Portland because he said he was at risk from prisoners there. He said he had drug debts totalling £6,000 from previous sentences and from outside prison.

48. On 1 July, Mr Barnes said he had changed his mind about going to Portland because it meant his family could visit him. His ACCT monitoring was reviewed and stopped the same day.

HMP Portland

49. On 12 July, Mr Barnes transferred to Portland. On 15 July, he told a nurse at a mental health triage assessment that he felt fine and did not require any contact with the mental health team. The same day Mr Barnes was referred to a recovery worker from the substance misuse team. He was subsequently given a job in the carpentry workshop.

50. On 28 July, Mr Barnes spoke to his keyworker. He said he was happy to be in Portland and was not using PS because it made him paranoid. He said that he wanted to work with the substance misuse team. Mr Barnes said he did not want to isolate in his cell as he had on his previous sentence.

51. On 5 August, Mr Barnes was involved in an argument with two other prisoners on the exercise yard. He later said he had been assaulted over a drug debt. The incident was referred to the safer prisons team under Prison Service violence reduction procedures (CSIP - challenge support and intervention programme) but did not proceed to a full investigation.

52. On 12 August, Mr Barnes attended a video-link meeting with his offender manager (community probation officer) and his offender supervisor (prison probation officer). Mr Barnes said he was afraid to leave the wing due to the assault on 5 August but said he was interested in working in the bicycle maintenance workshop. On 16 August, Mr Barnes moved to Raleigh wing, a standard residential wing.

53. On 21 August, a letter sent to Mr Barnes tested positive for PS. On 24 August, his keyworker said he was worried that Mr Barnes was not attending work because he was anxious about meeting certain prisoners on the way there. Mr Barnes said he was happy on Raleigh wing and did not want to isolate in his cell.

54. Mr Barnes continued to refuse to go to work over the next three weeks but on 16 September, he told his keyworker that he felt more confident and wanted to return to work and go to the gym.

55. During November, Mr Barnes started the Sycamore Tree Project (a victim awareness course) and his offender supervisor reported he was doing well. He also started working in the bicycle maintenance workshop and said he was enjoying it. His offender supervisor contacted Mr Barnes's local Halfords store with a view to him gaining employment there on release.

56. On 15 November, Mr Barnes failed to provide a urine sample for a mandatory drug test (MDT). On 24 November, he asked to isolate in his cell because he said he was being bullied over debts. He was referred under the CSIP process. This did not proceed to a formal investigation because he was unwilling to say who was bullying him. It was agreed that wing staff would keep an eye on him, and he was told he could move to another wing when space allowed. The same day, an officer submitted a security report after Mr Barnes told him he could hear another officer's voice talking to him through the wall at night and that he had not slept in three days. The next day, 25 November, Mr Barnes said he wanted to stop isolating.

57. On 27 November, Mr Barnes asked for an appointment with the mental health team. He also started sharing a cell with a friend of his. The same day, the mental health team were notified by the security department that Mr Barnes had said he was

hearing voices and not sleeping. Mr Barnes was added to the list for discussion at the next mental health team meeting.

58. The mental health team discussed Mr Barnes on 3 December and concluded his case was non-urgent. His medical record was noted “self-referral – MH deteriorating – added to waiting list – send letter”. The target period for assessment of non-urgent referrals was five days but Mr Barnes was not assessed before he died.

59. The mental health team leader told the investigator that, at that time, there was an average delay of fourteen weeks between referral and assessment for non-urgent cases due to staff shortages. The mental health team service specification is three nurses, however since January 2018, when she started her job, only two agency (non-permanent) nurses were employed. A recruitment exercise had failed to fill the posts and the mental health team hours had been reduced from 8.00am – 6.00pm Monday to Friday to 8.00am – 4.30pm. She said urgent referrals were seen within the two-day target, but no records had been kept to evidence this.

60. On 4 December, Mr Barnes asked to isolate in his cell because he said he was under threat from other prisoners on the wing. He said he was not under threat from his cellmate but did not wish his door to be open. His cellmate told the investigator that Mr Barnes had complained of a bad back and had told him some things in confidence that he did not wish to repeat.

61. On 8 December, Nurse A gave Mr Barnes some cream for dry skin on his hands and advised him to complete an application to see a GP about possible dermatitis. She told the investigator she did not remember meeting Mr Barnes that day and there is no evidence that he raised any issues about his mental health with her.

62. On 17 December, Mr Barnes saw the physiotherapist, for back pain. She did not find anything physically wrong with Mr Barnes and attempted to reassure him. She said Mr Barnes was “fixated on ‘being broken’” and had “poor beliefs”. She discharged him from the physiotherapy caseload.

63. On 21 December, Mr Barnes spoke to his sister on the telephone. He said he was “good” and would be coming home soon and not going back to prison. He spoke about the things he wanted to do when he was released. Later that day, Mr Barnes’s mother and one of his sisters visited him. The prison family liaison officer reported that, after Mr Barnes’s death, they told him that Mr Barnes had seemed fine at the visit.

Barricade and use of force on 23 December

64. At about 4.30pm, officers noticed that Mr Barnes had covered his observation panel and stuck items including broken CDs into the gaps around his door. A Supervising Officer (SO) said Mr Barnes initially appeared willing to remove the items so staff could open the door but then changed his mind.

65. A Custodial Manager (CM), the safer custody manager, said he knew Mr Barnes and had a good relationship with him, so he decided to go and talk to him to see if he could de-escalate the situation. He said Mr Barnes was talking in a peculiar manner and did not appear to have a grievance. He could not explain why he had made the barricade.

66. Mr Barnes did not appear to be under the influence of illicit substances and there was no evidence of substance misuse in his cell. The CM said he was concerned about Mr Barnes's state of mind and decided to begin ACCT monitoring. He completed the ACCT Immediate Action Plan to the effect that Mr Barnes should be located in a safer cell and checked hourly until his ACCT assessment and first case review the following day.

67. The SO returned to the cell after the CM radioed that Mr Barnes had decided to remove the barricade. He said Mr Barnes had removed a considerable number of objects from his door but then started replacing them. At 4.45pm, the SO and a CM decided to remove Mr Barnes to a safer cell for his own safety using control and restraint techniques (known as a planned use of force).

68. The investigator watched body-worn camera footage of the planned use of force. When Mr Barnes was brought out of his cell, at about 4.48pm, he had his dressing gown belt loosely tied around his neck and knotted more than once. Mr Barnes told the SO that he had wrapped the belt around his eyes to help him sleep. Mr Barnes said he had issues with other prisoners on the wing and wanted to move. He would not tell the SO which prisoners he had issues with.

69. Nurse A said she was on the wing dispensing medication and went to see what was going on when she saw officers in personal protective equipment (PPE). A CM called her over and asked her to witness the planned use of force. She said she did not have an opportunity to look at the prisoner's clinical record and was not told why force was necessary or who the prisoner was. She told the investigator that nurses were not always informed about planned uses of force. She felt that she had only been asked to monitor events on 23 December because the orderly officer had caught sight of her.

70. Nurse A said she was not sure what Mr Barnes had around his neck and thought it might have been clothing. She described it as "a ligature" and said she was worried about his airway. The officers put Mr Barnes into a safer cell and shut the door. She spoke to Mr Barnes through his observation hatch, but he shook his head and gestured for her to go away. She could not see any redness around his neck, and he appeared to be breathing normally. She said she decided to refer Mr Barnes to the mental health team for assessment.

71. Nurse A did not complete the form used to report injuries to prisoners (F213), which is a mandatory requirement after a use of force. She said this was usual practice at the time and officers had only recently (at the time of interview in May 2020) asked attending nurses to do so. She said that she was present in the healthcare department when a significant amount of use of force paperwork was delivered and nurses were asked to check clinical records to determine whether a nurse had been present and a F213 completed in each case.

72. Nurse A made an entry on the ACCT record but did not refer to a ligature or her intention to make a referral to the mental health team. She said she did not make an entry on Mr Barnes's medical record because she was about to go off duty. She said she knew she would be in very early the next morning and could do so then. She was also reassured by the fact that Mr Barnes was subject to ACCT monitoring and therefore a mental health nurse should attend his first case review the following day.

24 December

73. When she arrived at the prison on 24 December, Nurse A made an entry on what she thought was Mr Barnes's medical record. She said she remembered hearing the officers referring to 'Barnes' the day before and, when she searched for that name, there was only one prisoner in Portland called Barnes. She did not know that Mr Barnes's clinical record was in a different name. She made an entry in the wrong record and referred the other Mr Barnes to the mental health team. She said she handed over what had happened to the mental health team leader at about 10.30am and at the lunchtime handover meeting. The team leader said she did not remember the nurse speaking to her about Mr Barnes.

74. Mr Barnes declined to attend an ACCT assessment with an officer at 9.30am. The officer said he knew Mr Barnes and thought this was unusual, but he was not overly concerned because he thought another ACCT assessor would be allocated to review Mr Barnes that afternoon. Mr Barnes was not assessed that afternoon, but we do not know why.

75. The mental health team leader said the security department notified her by email at 11.23am on 24 December that Mr Barnes was subject to ACCT monitoring because he had behaved strangely and had tied a dressing gown cord around his neck. They also referred him to the mental health team. She said she did not make an entry in Mr Barnes's clinical record about this because she was the only member of the mental health team in that day and had eight referral appointments and two ACCT reviews to complete. She acknowledged that she had not made a retrospective entry.

76. The mental health team leader said if a prisoner was in distress, the wing staff would usually ring her. She expected to be invited to the first ACCT case review and thought that she probably assumed everything was alright and she would see Mr Barnes then. In her interview, she said that the mental health team was under particular strain over Christmas because one of the agency nurses was on leave and attendance at first ACCT reviews was therefore erratic.

25 – 26 December

77. A SO and an officer completed a joint ACCT assessment and first case review at 8.30am on 25 December. The SO said he knew Mr Barnes and asked to sit in on the ACCT assessment. The SO did not invite a member of the mental health team to the review as he should have done. He was also unaware that Nurse A had referred Mr Barnes to the mental health team because she had not written it on the ACCT.

78. Mr Barnes was offered the opportunity to have his family involved in the ACCT process but declined. He said had been "overthinking things" and had barricaded his door because he did not want to come out of his cell for a couple of days until he "got his head sorted". He said his dressing gown belt was not a ligature. He denied feeling suicidal and said he had only ever harmed himself once before, due to anxiety before being released from a previous sentence.

79. Mr Barnes told the SO that he had a parole hearing in January, had "everything to live for" and was in regular contact with his family. The SO decided to continue

ACCT monitoring to support Mr Barnes through the parole process and because of his previous self-harm before release. He set observations at one conversation daily and four random observations overnight because Mr Barnes appeared positive at his review.

80. The SO added two actions to Mr Barnes's caremap (a list of planned actions to reduce the person's risk): that he should remain in the safer cell until he felt able to return to his own cell and that he should talk to staff as necessary.

81. At 3.54pm on 26 December, Mr Barnes spoke to his mother on the telephone for almost five minutes. They talked about Christmas and Mr Barnes said he was "alright" but complained about the food and a bad stomach. His mother said, "Only three weeks left" and Mr Barnes replied, "See what happens". He said he would phone his sister the next day.

82. The same day Mr Barnes moved from the safer cell back to his previous cell on Raleigh wing.

28 December

83. The prison sent CCTV from 28 December to the investigator, but she was unable to get it to play. She could not visit the prison to watch it on their equipment because of lockdown measures due to the COVID-19 pandemic. She asked the prison to identify all the staff who visited Mr Barnes's cell that day but, despite repeated requests, they did not provide the information. The investigator was provided with a printout of Mr Barnes's cell bell record from 20 – 28 December, but the cell call system clock is almost three hours later than the actual time. Timings have therefore been taken from the HMPPS early learning review conducted by the area safer custody lead in January 2020.

84. At lunchtime on 28 December, prisoners working on the servery noticed that Mr Barnes was holding his plate awkwardly and told officers. Nurse B said that she received a call at about 2.00pm because officers were concerned Mr Barnes had hurt his wrist. She tried to find his medical record before going to the wing but was unable to do so. She found records for the other Mr Barnes, but he was not on Raleigh wing. Wing staff later explained to her that Mr Barnes's medical records were under a different name.

85. CCTV shows Nurse B went to Mr Barnes's cell at 2.03pm. She said he moved his wrists in circles to show her he was unhurt and appeared to be in good spirits. He asked the officer present why he was making a fuss over nothing. She said there was nothing to concern her about Mr Barnes's behaviour. She was not made aware by wing staff that Mr Barnes was subject to ACCT monitoring as she should have been. CCTV shows she left Mr Barnes's cell at 2.04pm.

86. Nurse B said she did not write up her interaction with Mr Barnes on his clinical record immediately because she was asked to check prisoners in the segregation unit and she then attended a cell fire on another wing. She said she was about to write up her visit to Mr Barnes later that day when she was called to another prisoner who had cut his throat. The incident involved a planned use of force and took a significant time to resolve. (She made a retrospective entry on Mr Barnes's medical record on 30 December after he had died.)

87. Mr Barnes pressed his emergency call bell four times during the afternoon of 28 December: at 2.30pm (responded to at 2.33pm), 2.45pm (responded to at 2.58pm), 3.14pm (responded to at 3.31pm) and 4.20pm (responded to at 4.21pm). No entries in the wing observation book refer to Nurse B's visit or to Mr Barnes pressing his cell bell.

88. An officer was on duty on Raleigh wing that day. She said she remembered answering Mr Barnes's cell bell in the afternoon but could not remember what time that was. She said asked Mr Barnes if he was okay, and he said he was but asked for an inhaler. She asked him if he needed it immediately, and he said that he wanted to come out and collect it in the morning. She told him that was fine, and she would put him on the list for morning medications.

89. The officer said Mr Barnes did not ask for anything else or say anything else to her. He seemed to be fine, and she did not notice anything out of the ordinary. She did not remember Mr Barnes pressing his cell bell so often that afternoon and said she was surprised to see the record from that day. She said it was possible she had answered one of the other bells, but she only remembered doing so once.

90. The cell bell record for the week leading up to Mr Barnes's death showed his bell had only been pressed once between 20 – 27 December, and it is possible that it was pressed on that occasion by an officer completing an Accommodation Fabric Check. We have not seen the cell bell record for the safer cell, where Mr Barnes was located between 23-26 December.

91. At 4.33pm, an officer checked Mr Barnes during roll count. According to the Early Learning Review this is the last time anyone checked Mr Barnes before he died. Without access to CCTV, we were unable to independently verify this.

The emergency response

92. (As above, timings have been taken from interviews, prison records and the HMPPS Early Learning Review.)

93. An Operational Support Grade (OSG) arrived on Raleigh for his night patrol shift at about 8.15pm. He received a handover from Officer A and began a roll count. He said he started his count on the third landing and then made his way to the second landing. A prisoner asked him the time and he remembered it was 8.20pm. Very shortly afterwards he checked Mr Barnes's cell.

94. The OSG said he saw Mr Barnes suspended by a sheet from the end of his upturned bed. He radioed a code blue emergency to signify a prisoner not breathing. Officer A arrived quickly, and they entered the cell.

95. Officer A said Mr Barnes had put his mattress against the door to obstruct entry and he had to force the door open. Mr Barnes was fully suspended from the crosspiece of his upturned bed by a ligature made from his sheet. He cut the ligature, laid Mr Barnes on the floor and began cardio-pulmonary resuscitation. He dropped his cut down tool (known as a fish knife) as he put Mr Barnes on the floor and was unable to completely remove the ligature from Mr Barnes's neck before he started chest compressions. He said Mr Barnes was blue, cold and not breathing.

96. Officer B responded from the unit next door. He heard Officer A shout for a defibrillator and went to the fire hood box as that had a sign indicating the defibrillator was inside. It was not there, so he shouted to Officer A who told him it was in the wing office. He retrieved it and went to Mr Barnes's cell.

97. Officer A had done three rounds of 30 chest compressions, so Officer B took over. He said the ligature was still around Mr Barnes's neck, but someone removed it as he began compressions. Officer A attached the defibrillator to Mr Barnes. The defibrillator advised no shock and Officer C alternated sets of compressions with him.

98. Officer B said that he had received training in advanced trauma care just before he left his job as a coastguard less than a year before. He was previously an advanced life support instructor and had also received a basic life support refresher as part of his officer training. He said, in his experience, when he first saw Mr Barnes, he thought that he had been without oxygen for too long to save his life. He said Mr Barnes's airway appeared too compromised for oxygen to be successfully delivered by bag and mask, so he had not asked for any further equipment from healthcare staff.

99. The radio system showed the code blue was called at 8.18pm. The control room log, which used the time on the clock in the control room, showed it was received at 8.25pm and the ambulance was called at 8.26pm. South Western Ambulance Service records showed the 999 call was received at 8.28pm.

100. The ambulance arrived at the prison at 8.44pm. Paramedics recorded that Mr Barnes's pupils were fixed and dilated, he had rigor mortis in his jaw and hypostasis (pooling of the blood – a sign of death) was evident in his hands. For these reasons, they did not give Mr Barnes advanced life support and declared he had died at 8.50pm.

Contact with Mr Barnes's family

101. The Governor and the prison's family liaison officer drove to Mr Barnes's next of kin's house and broke the news of his death at 2.00am. The prison contributed to the cost of Mr Barnes's funeral in line with national guidance.

Support for prisoners and staff

102. After Mr Barnes's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

103. The prison posted notices informing other prisoners of Mr Barnes's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Barnes's death. Mr Barnes's cellmate said that he had received support from the chaplaincy.

Post-mortem report

104. The pathologist concluded Mr Barnes died from ligature suspension (hanging). Toxicology tests showed that he was not intoxicated by alcohol or drugs when he died.

Findings

General healthcare

105. Mr Barnes's clinical records were in a different name to his prison records and this fact twice caused confusion in the last days of his life. Although it is not possible to say whether this confusion affected the outcome for Mr Barnes, it is a fundamental principle underpinning all healthcare interactions that practitioners must assure themselves of the identity of the patient. We consider that neither Nurse A nor Nurse B made sufficient efforts to identify who they were dealing with on 23 and 28 December respectively.

106. We also consider that Mr Barnes's medical records were insufficiently clear that he was known under two names. Both names were identified in the footer of every page on his record, but when the nurses searched for him by the name Barnes, his records were not returned in the results. Not being able to identify a prisoner's correct records when needed easily can have serious consequences. We make the following recommendation:

     The Head of Healthcare should identify prisoners at HMP Portland whose clinical record is in a name different to the one used by the prison and, together with the SystmOne IT lead, should review the process for flagging such patients to ensure that clinical staff are able to identify their records from either name.

Mental health

Mr Barnes's mental health care

107. Mr Barnes was supported by the mental health team during several previous sentences at Portland, including in the period leading up to his release on licence in June 2019. His application to see the mental health team on 27 November coincided with information provided to healthcare by the security department that he was hearing voices and had not slept for three days. Mr Barnes's application was not scanned on to his clinical record, as it should have been, and there is no evidence that it was taken into consideration by the mental health team when they triaged his case on 3 December. It is also not clear from the records whether the information from the security department was taken into consideration.

108. We agree with the clinical reviewer that this information, combined with Mr Barnes's history of mental health engagement, should have raised his priority for assessment. Given the extremely long delays for non-urgent assessments at the time - of around 14 weeks – it was imperative that mental health staff considered all available information to satisfy themselves that such a significant delay would be safe.

109. Nurse A's referral of the wrong prisoner to the mental health team on 24 December was a further missed opportunity to re-prioritise Mr Barnes's need for a mental health assessment. If her referral had been on the right clinical record, it would have lent weight to the email and referral from the security department to the mental health team leader on the same day alerting her to ACCT monitoring, Mr Barnes's

"bizarre" behaviour and ligature. Moreover, this would have made four referrals of the same prisoner in less than a month. Together these should have provided a developing picture of a young man in need of urgent assessment. We recommend:

The Head of Mental Health should ensure that all available information is taken into consideration when triaging a prisoner for mental health assessment, in particular:

- **further information should be obtained from the security department where it is indicated that relevant information has been received; and**
- **relevant prisoner's applications should be scanned on to their clinical record.**

Mental health services at Portland in general

110. This investigation has identified severe problems with the provision and oversight of the mental health service at HMP Portland including:

- chronic recruitment and retention issues;
- very limited service provision;
- lack of oversight;
- failure to monitor delays;
- a failure to escalate the problems to the commissioners effectively; and
- no strategic action to deliver widespread change.

In particular, the delays for non-urgent mental health assessments were unacceptable. Attendance at ACCT reviews was erratic and came at the expense of mental health clinics because there were insufficient staff to cover both.

111. In the light of these failings, the clinical reviewer concluded that the healthcare received by Mr Barnes was not equivalent to that he would have received in the community.

112. These issues are not new. The mental health team leader said the staffing situation dated from at least January 2018, and both the most recent HMIP and IMB reports concluded that health services as a whole and mental health in particular did not meet the service specification and were not functioning effectively.

113. The mental health team leader told us that, since Mr Barnes's death, she had made some changes to the referral process to improve triage and increase the dedicated slots for urgent referrals. She also said that non-urgent referrals were now seen within the five-day target. This was largely made possible by the restrictions imposed as part of the COVID-19 pandemic which had reduced the number of prisoners admitted to Portland. It is unlikely to be sustainable once these measures are reduced.

114. We make the following recommendation:

The NHS Commissioner should urgently review the mental health service at HMP Portland with the Governor and Head of Healthcare and ensure the service specification is met and an effective service is delivered to all prisoners.

ACCT procedures

115. We consider that it was appropriate for a CM to initiate ACCT monitoring on 23 December and the prison did some things well. Mr Barnes was moved to a safer cell on a standard wing instead of being moved to the segregation unit. This was rightly a compassionate response to a young man behaving oddly rather than a punitive response to a young man breaking prison rules. Wing managers spoke to Mr Barnes at length the same evening in advance of an ACCT assessment to try to find out why he had acted so out of character. At the first review, the SO decided that ACCT monitoring should continue until Mr Barnes was released, in recognition that this was often a stressful time and that Mr Barnes had self-harmed due to stress about his previous release in June 2019.

116. However, we have identified several weaknesses in the ACCT process from which the prison must learn:

- It is a mandatory action under Prison Service Instruction (PSI) 64/2011 that the ACCT assessment and first case review take place within 24 hours of ACCT monitoring starting. If the prisoner declines to attend an assessment, as Mr Barnes did on 24 December, the assessment should be completed in the prisoner's absence based on all available information.

- The ACCT assessment and case review took place at the same time. This is not good practice as the two interviews have different purposes. The ACCT assessment is a 1:1 interview focussing specifically on risk assessment. Case reviews should be multi-disciplinary (or at least involve more than one person). Prisoners might feel more able to talk or divulge sensitive information about their risk in a 1:1 interview.

- No one from healthcare attended the first ACCT review, another mandatory requirement of (PSI) 64/2011. This was especially important given the concerns about Mr Barnes's mental health at the time of the barricade, information received in November that he was hearing voices and not sleeping and his outstanding mental health assessment.

- When Nurse B was called to see Mr Barnes on 28 December, she was not made aware that he was subject to ACCT monitoring, as she should have been.

- The caremap contained two actions – for Mr Barnes to remain in the safer cell until he decided he was ready to return to his own cell and for him to talk to staff when he needed to. We consider that it was wrong to place the responsibility for these actions on to Mr Barnes. ACCT is a multi-disciplinary process and should be led by staff. A decision to move Mr Barnes from the safer cell should have been based on an assessment of his risk at a case

review. The second action is not an appropriate caremap action as it should be implicit in the ACCT process, which involves daily conversations.

- The hourly checks in the period leading up to the assessment and first case review appear to have been at predictable intervals. There is insufficient evidence on the on-going record that staff had daily conversations of any substance with Mr Barnes. Mr Barnes's unusually frequent bell presses on 28 December do not appear to have been explored.

117. We gave feedback to the prison at an early stage, and this, combined with the area safer custody lead's early learning review, has already resulted in some changes. A new local operating procedure for how the mental health team support the ACCT process was put in place in the first quarter of 2020. The investigator asked for updates on other changes made in response to the early learning review following Mr Barnes's death so they could be reflected in this report, but she did not receive a reply. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that staff manage prisoners identified as at risk of suicide and self-harm in line with national guidelines including:

- **assessments and first case reviews should take place within 24 hours of the start of ACCT monitoring;**
- **assessments and case reviews should be separate;**
- **a member of the healthcare team must attend the first case review;**
- **all staff visiting the wing should be made aware if the prisoner they are seeing is subject to ACCT monitoring;**
- **caremap actions should be specific and meaningful and aimed at reducing the prisoners' risks to themselves; and**
- **ACCT documents should be completed fully and accurately, including following the prescribed level of observations at irregular intervals and recording them.**

The Governor should ensure that the decision to move a prisoner from a safer cell to a standard cell is taken at an ACCT review.

Use of force 23 December

118. Prison Service Order (PSO) 1600 covers planned and unplanned uses of force. It is a mandatory requirement that a nurse is present at a planned use of force "whenever reasonably practicable" and Paragraph 6.7 says that they are responsible for monitoring "whether the prisoner is still breathing and still conscious throughout the incident". Paragraph 6.9 says:

> "He or she must examine the prisoner as soon as possible [after a use of force] and must complete a F213 [report of injury to inmate form] in all cases even if the prisoner appears not to have sustained any injuries. The prisoner

must see an appropriately qualified healthcare professional within 24 hours of the incident happening."

119. Although Nurse A was present during the planned use of force on Mr Barnes, she said she thought this was only because the orderly officer happened to see her, and she did not appear to appreciate that it was her responsibility to monitor Mr Barnes's health and safety. She did not complete form F213, and Mr Barnes was not examined by a nurse within 24 hours.

120. Nurse A said healthcare staff did not routinely complete F213 forms and she appeared to place the responsibility for ensuring their completion on to prison staff. We understand that she was not helped by what appears to be a culture of not involving healthcare staff in planned use of force, but it was her responsibility as the attending nurse to do so and we are concerned that she did not understand her important responsibilities. HMIP identified a concern about use of force paperwork and procedure in July/August 2019 and recommended use of force documentation should be completed promptly and thoroughly. It is concerning that the same lax practices were still in evidence in late December 2019.

121. We recommend:

The Head of Healthcare should ensure that all healthcare staff understand their responsibilities during and after a use of force, as set out in PSO 1600.

The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.

Emergency Response

122. Overall, the response to finding Mr Barnes hanging was timely and efficient. However, we have identified some learning – although this would not have changed the outcome for Mr Barnes.

123. When he arrived on Raleigh wing in response to the code blue, Officer B looked for the defibrillator in the fire hood cover because a sticker on it indicated one was inside. In fact, the defibrillator was in the wing office, which is the usual location for defibrillators at Portland. The short delay collecting it did not affect the outcome for Mr Barnes, and we are satisfied that the misleading sticker has been removed and we therefore we make no recommendation about this.

124. Officer A managed to cut the ligature from the bedframe and lay Mr Barnes on the floor on his own. In doing so he lost his cut down tool before he had removed the ligature from Mr Barnes's neck. He told the investigator that he believed Mr Barnes's airway was clear and oxygen was getting into his lungs. On the balance of probability this is very unlikely if there was a ligature around his neck, and ligatures must be removed to ensure effective CPR.

125. We do not criticise Officer A, who was concerned to provide Mr Barnes with immediate aid, and we recognise that he was performing a difficult task single-handedly. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are aware that ligatures should be removed before resuscitation is attempted.

126. We understand the commendable wish to attempt and continue resuscitation until death has been formally confirmed, and we acknowledge that no healthcare staff were on duty in the prison to take responsibility and make a clinical decision. However, there was evidence that Mr Barnes was already dead when he was found. He was cold, his jaw was stiff and there was post-mortem blood pooling in his hands. Officer B was sufficiently experienced to know that Mr Barnes was beyond resuscitation, but he believed that prison staff were required to attempt CPR until someone qualified pronounced death.

127. This is not the case, although it is a common misperception among prison staff. The European Resuscitation Council Guidelines for Resuscitation 2010 state that "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". Attempting resuscitation in these circumstances is distressing for staff and is not in accordance with the principle that the deceased be treated with respect and dignity. We do not criticise the staff involved but we make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

128. There is a seven-minute difference between the time of the 999-call recorded on the radio system and that recorded on the clock in the control room. Based on South West Ambulance records we are satisfied that the clock in the control room is more accurate and that there was no delay calling the ambulance.

Liaison with the PPO

129. The investigator was not provided with all the information and evidence she requested from the prison, even after repeated requests. We appreciate that there have been difficulties during the pandemic, but we need to record that liaison was poor when compared to other prisons. We recommend:

The Governor should ensure that the prison's designated liaison officer cooperates fully with all requests from the PPO for information, material or access to establishments and prisoners in line with PSI 58/2010.

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