Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Port, a prisoner at HMP Hull, on 11 May 2021

A report by the Prisons and Probation Ombudsman

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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

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 Port died from sertraline and paramethoxy-amphetamine (PMA) toxicity on 11 May 2021 at HMP Hull, having taken an apparently deliberate overdose of antidepressant medication and an illicit drug. He was 48 years old. I offer my condolences to Mr Port's family and friends.

Mr Port had been in prison for 17 months when he died and had just over a year of his sentence left to serve. As is common in first time prisoners, Mr Port struggled in his early days in prison and reported increased symptoms of anxiety. However, he appeared to settle well at Hull, having been appointed to a trusted job which he enjoyed, and staff who knew him, as well as his cellmate, thought that he had few issues or concerns. Mr Port left a note which indicated that he was worried about his sentence progression and issues with withheld property.

Mr Port's death is a reminder of the stresses that many prisoners serving medium or long-term sentences face, and which, to a large extent, Mr Port seems to have hidden at Hull. I consider that there was little to indicate to staff that he was at imminent risk of suicide and it would have been difficult to have predicted or prevented Mr Port's actions.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **February 2022**

Contents

Summary

Events

1. On 11 October 2019, Mr David Port was sentenced to five years and four months in prison. This was his first time in prison.

2. Mr Port had previously attempted suicide in the community and had once been admitted to a psychiatric hospital under the Mental Health Act as a result of suicidal ideation. At the time of his sentencing, Mr Port was prescribed medication for depression and anxiety.

3. In his first weeks in prison, Mr Port said that he was experiencing increased anxiety. He began to settle into prison life and started work helping older prisoners on his wing. In August 2020, staff started Prison Service suicide and self-harm prevention procedures (known as ACCT) after Mr Port spoke of symptoms of increasing anxiety. A few weeks earlier he had resigned from his job after telling staff he found it overwhelming. Prison staff closed the ACCT procedures after a week when Mr Port said that he felt considerably better.

4. Over the following months, Mr Port twice referred himself to the mental health team, each time reporting symptoms of stress. He was assessed after each referral and discharged from the mental health team's caseload in January 2021.

5. Later that month, Mr Port began working in the prison grounds, a job given to trusted prisoners. He told staff that he enjoyed the job. Prison staff who knew him, as well as Mr Port's cellmate, told us that he had few issues in prison and seemed to be progressing well.

6. On the morning of 11 May, staff could not rouse Mr Port. A nurse identified that he had low blood glucose levels (Mr Port was a Type 1 diabetic) and treated him with glucose gel and an injection. Shortly after she administered the injection, Mr Port experienced a cardiac arrest. Prison staff began cardiopulmonary resuscitation but, later that morning, paramedics confirmed that he had died.

7. The post-mortem found that Mr Port died as a result of a drug overdose. Mr Port left a note in his cell which indicated that he had intended to end his life.

Findings

8. Mr Port had some historic risk factors for suicide and self-harm. After struggling in his first months in custody, he had apparently settled well into prison and had a job. We are satisfied that in the days and weeks leading to his death, there was nothing to indicate that he was at increased risk of suicide and self-harm. We consider that it would have been difficult for staff at Hull to have foreseen his death.

9. Mr Port's note indicated that he was upset about religious books that had been withheld from him due to their content. We found that Mr Port's withheld property was not managed in line with national guidelines.

Recommendations

- The Governor should ensure that temporarily confiscated property is properly recorded and stored and that prisoners are informed of the reasons for the confiscation in line with national instructions.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact him. He obtained copies of relevant extracts from Mr Port's prison and medical records.

11. The investigator interviewed seven members of staff and one prisoner at Hull. NHS England commissioned a clinical reviewer to review Mr Port's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the restrictions in place in response to the COVID-19 pandemic.

12. We informed HM Coroner for Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Port's parents to explain our investigation and to ask if they had any matters they wanted us to consider. They asked for clarification about Mr Port's cause of death and whether his diabetes was managed appropriately in prison.

14. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies.

15. We also shared the initial report with Mr Port's parents. They provided some details which we have added to this report.

Background Information

HMP Hull

16. HMP Hull is a local prison that holds up to 1,056 men. City Healthcare Partnership provides health services. J wing is for vulnerable prisoners (those who are separated from the main population, usually because of the type of offence they have committed) and holds up to 130 men.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Hull was in July 2021. Inspectors reported that measures to reduce the supply of drugs were appropriate. They found evidence that the misuse of drugs had lessened since their previous inspection (in 2018), including a significant reduction in the number of prisoners who said it was easy to obtain illicit drugs. Inspectors also reported that mental health services were not properly resourced, and a number of prisoners had needs that were not being met.

Independent Monitoring Board

18. 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 February 2021, the IMB reported that incidents of self-harm had reduced by 26 per cent during the reporting year. They reported an increase in the number of attempts to send illicit drugs into the prison but said that staff actions, including intensive searching, had limited prisoners' access.

Previous deaths at HMP Hull

19. Mr Port was the thirteenth prisoner to die at Hull in the last two years. Five of the previous deaths were self-inflicted. There are no significant similarities between Mr Port's death and those of the other men.

Assessment, Care in Custody and Teamwork [ACCT]

20. 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. 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 multi-disciplinary review meetings involving the prisoner.

21. 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. 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.

Key Events

22. Mr David Port had contact with community mental health services for much of his adult life, having been diagnosed with an anxiety disorder and avoidant personality disorder. At periods in his life, he was prescribed antidepressants and antipsychotics. In 2012, Mr Port was admitted to a psychiatric hospital under the Mental Health Act after disclosing suicidal intent when he was charged with possessing indecent images. (Mr Port later received a community sentence for this offence.)

23. At various times in his life, Mr Port told mental health professionals about previous suicide attempts. This included attempting suicide by overdose, jumping in front of a train and electrocution. While serving his community sentence, he said that he had considered injecting himself with a large amount of insulin. (Mr Port was a Type 1 diabetic, which meant that he had to inject himself with insulin every day to control his blood glucose levels as his body did not produce enough insulin to do this naturally.)

24. When he was sent to prison, Mr Port was prescribed sertraline (an antidepressant) and propranolol (medication for anxiety) and insulin.

HMP Hull

25. On 11 October 2019, Mr Port was sentenced to five years and four months in prison for the indecent assault of a child and was sent to HMP Hull. It was his first time in prison. On arrival, Mr Port told prison and healthcare staff that he had not previously tried to harm himself. He described a history of anxiety and depression and was referred to the mental health team.

26. On 15 October, a member of the chaplaincy recorded that he had been asked to see Mr Port as he had not been allowed to keep some of the religious books he had brought into prison with him. He recorded that he had emailed reception about this. Mr Port raised the problem with access to his books again in November when he spoke to another member of the chaplaincy team and to his prison officer key worker.

27. On 28 October, a mental health nurse assessed Mr Port who said that his anxiety had initially been worse when he arrived in prison but that he was now beginning to settle and cope better. Mr Port agreed to attend a mental health support group. A few weeks later, Mr Port's propranolol prescription was stopped, and he was only prescribed sertraline.

28. On 12 November, a diabetes specialist nurse reviewed Mr Port. She gave Mr Port advice and encouraged him to check his blood glucose levels daily and record the results. (Mr Port subsequently began to complete a diary of his blood glucose levels.)

29. Over the following months, Mr Port reportedly settled well into prison life. He began to work as a care buddy (assisting older or disabled prisoners with daily activities) on J Wing and was awarded enhanced status on the prison's Incentives and Earned Privileges (IEP) scheme (which aims to encourage and reward responsible

behaviour in prisons). Mr Port's key worker recorded that he was positive, happy and doing well.

30. At the end of March 2020, the prison's regime was severely reduced in response to the COVID-19 pandemic and prisoners spent much longer in their cells.

31. On 2 July 2020, Mr Port referred himself to the mental health team, saying that he had fleeting thoughts of ending his life. At around the same time, Mr Port resigned from his job as a care buddy, telling staff that he found it overwhelming.

32. On 16 July, a mental health nurse assessed Mr Port. He said that his mood had improved since he submitted the application, although he continued to experience stress and difficulty sleeping. The nurse referred him to the prison doctor for a medication review. She recorded that there was no further support that the mental health team could offer and discharged him from their caseload.

33. On 9 August, Mr Port told a prison nurse that he was experiencing anxiety, poor concentration, a lack of sleep and that he thought he could hear people talking about him. He also said that he was concerned he had missed insulin doses or might take too much. The nurse started ACCT procedures, arranged for Mr Port's insulin and sertraline to be removed from his cell and referred him to the mental health team. (Mr Port had previously been allowed to keep sertraline, insulin and needles in his cell to take in line with his prescription. Removing them meant that he had to attend the wing medication hatch to have medication administered by a nurse.)

34. On 17 August, a supervising officer (SO) ended ACCT procedures following a case review at which Mr Port said that he was "100 times better". Mr Port said that he felt very supported by staff and that his diabetes was more controlled.

35. On 26 August, a mental health nurse assessed Mr Port. He described previous suicide attempts and said that he had no current thoughts of taking his life. He said that he worried about his diabetes which he struggled to keep controlled. Mr Port also said that he thought he was "hypersensitive" to what other people thought of him. The nurse recorded that there was no evidence of depression or anxiety. She concluded that no further input from the mental health team was needed and discharged Mr Port from the service.

36. In September, a nurse reassessed Mr Port's risk of keeping medication in possession. He was again permitted to keep his medication in his cell to take as prescribed.

37. On 6 October, a mental health nurse assessed Mr Port as he had applied to be seen due to increased stress. Mr Port said that his stress levels had since reduced. The nurse gave him some self-help packs and discharged him from the service.

38. In November, Mr Port told a prison chaplain that he had been told he could not have access to some religious books in his property. (Mr Port was a Jehovah's Witness and the chaplain told us that his faith was very important to him.) The chaplain recorded that he followed this up afterwards and, on 11 December, he noted that the release of the books had "now been authorised by a Gov, and a list of which books to be released to him has been sent to a CM for action". On 22 December,

the chaplain recorded, “After further and viewing these books, security/reception made a decision not to release them to him due to some of their contents. This has been explained to David.” (There is no record of this in Mr Port’s prison record.)

39. On 7 December, Mr Port referred himself to the mental health team, saying that he was experiencing increasing anxiety and difficulty concentrating. An officer recorded that Mr Port was “stressing” about everything going on around him.

40. On 4 January 2021, a mental health nurse assessed Mr Port. He recorded that Mr Port had felt forgetful over recent weeks, which Mr Port attributed to stress, but that he felt much better now. Mr Port said that he was worried about managing his diabetes effectively and was awaiting an appointment to discuss this further. Mr Port requested self-help material, which was provided, and was discharged from the mental health team’s caseload with no further action required.

41. Over the following weeks, staff recorded that Mr Port was well and feeling better than recently.

42. On 27 January, Mr Port started work looking after the prison’s chickens. Prison staff told us that this was a particularly trusted role as it meant that he spent much of the day outside with minimal supervision.

43. On 3 February, a prisoner began to share a cell with Mr Port. The prisoner told us that Mr Port initially found prison “a bit of a trial” as he found it difficult having nothing meaningful to do. He said that Mr Port became more “laid back” and content when he began working with the chickens and that he had a small group of friends of a similar nature with whom he spent time. He said that he did not think that Mr Port had any significant issues in prison.

44. On the same day, Hull’s diabetic specialist nurse conducted Mr Port’s annual diabetic review. She recorded that no issues were identified, that Mr Port felt that he was managing well and that he had a good understanding of his diabetes.

45. On 12 March, an officer recorded that he had spoken to Mr Port about his “poor work ethic” in the chicken yard. Later in the month, other officers recorded that Mr Port was enjoying his job and had no issues other than waiting for some religious books to be sent into the prison.

46. On 9 April, reception staff recorded six “inappropriate” books in Mr Port’s stored property. An operational manager told us that there was no contemporaneous record of why the books were considered inappropriate. He said that reception staff later told him that they remembered that the books contained references to children that were not permitted for Mr Port due to his offence. He said that two reception staff told him that they had “communication” with Mr Port about this at the time. (There is no note of this communication in Mr Port’s prison records.) Mr Port’s parents told us that one of the confiscated books was a Bible leant to Mr Port by an Elder.

47. On 12 April, an officer recorded that Mr Port told him that he was doing “okay” and had no issues or concerns. Mr Port said that he enjoyed working outside.

48. On 27 April, Mr Port spoke to a prison chaplain about problems that he was experiencing receiving religious books that he had ordered. The chaplain recorded

that he followed this up afterwards and identified that some religious books Mr Port had asked to be posted out of the prison had gone, and that others had arrived and were being processed by the reception team.

49. The chaplain told us that Mr Port had initially struggled with prison but, over time, began to settle and was progressing well. He said that Mr Port had a small group of friends, including his cellmate, with whom he socialised, and that he loved his job working with the chickens. He told us that in the weeks before Mr Port's death, he often had a chat with him through the fence as he passed by the chicken yard. He said they spoke about the books which he was trying to help Mr Port with and added,

> "But in all those conversations which were very, very general, there was no indication of him not handling prison life or any indication that he was more upset or struggling. They've been within what I would call the boundaries of normal."

50. Other staff also spoke to us about Mr Port's progress in prison. An officer described Mr Port as a kind, quiet man who enjoyed his work outside. He said that he was not aware that Mr Port had any issues or concerns after the ACCT procedures were closed in August 2020. Another officer said that Mr Port was a quiet man who was always busy, either working or socialising with his friends. She told us that Mr Port did not tell her of any issues or concerns.

51. On 3 May, an officer spoke to Mr Port as part of a welfare check. He recorded that Mr Port engaged well and enjoyed his work with the chickens and that he was in touch with his family via phone and had received a virtual (video link) visit.

52. On 10 May, an officer conducted a welfare check and spoke to Mr Port while he was working in the chicken yard. He recorded that Mr Port said he was "okay" and was in touch with his family and did not raise any issues. He told us that there was nothing unusual about their conversation and that he had no concerns about Mr Port's mental health or risk of suicide and self-harm.

53. Mr Port's cellmate told us that Mr Port appeared happy on 10 May, and that his evening routine was the same as usual.

11 May 2021

54. Mr Port's cellmate told us that he woke at around 7.30am to 7.45am and could hear Mr Port snoring. Between 8.00am to 8.20am, Officer A unlocked the cell so that the cellmate and Mr Port could go to work. The cellmate said that he told her that he could not rouse Mr Port.

55. Officer A told us that Mr Brown said that Mr Port had not been well in the night and was having a "diabetic crisis". She said that she tried to rouse Mr Port but heard only "mumbling". She therefore went to the wing medication hatch, where a nurse was working.

56. The nurse told us that she went to the cell and spoke to Mr Port and that he "mumbled" in reply. She tested his blood glucose level, which was 1.9mmol/L. (A normal blood glucose level for a Type 1 diabetic upon waking is 5 to 7mmo/L.) The

nurse therefore gave Mr Port glucogel (to raise blood glucose levels quickly), which she massaged into his mouth.

57. After waiting a few minutes for the gel to take effect, the nurse checked Mr Port's blood glucose level, which was now 2.3mmol/L. She told us that Mr Port was still semi-conscious and his condition had not changed. The nurse then asked Officer A to contact the pharmacy for a glucose injection, which was subsequently brought to the cell and administered.

58. Officer B, who had attended the cell when Officer A fetched the nurse, said that Mr Port's breathing became laboured and that the nurse therefore requested an ambulance at this point. He said that while they were waiting for the ambulance, Mr Port's fingers began to turn blue and he stopped breathing, after which they began cardiopulmonary resuscitation. (The nurse's account of when the ambulance was called differed slightly from Officer B's account. Body-worn camera footage taken by Officer A supports Officer B's account.)

59. The control room operator recorded a code blue medical emergency radio message at 8.38am and telephoned for an ambulance immediately. At 8.54am, paramedics arrived at Mr Port's cell. At 9.39am, they confirmed that Mr Port had died.

60. After Mr Port's death, prison staff found a note in his diary, dated 10 May, which said, "Forgive me, Jehovah". They also found a longer note, also dated 10 May, in which Mr Port wrote that he had been "tortured" over the loss of his religious books which had been "stuck in reception for over a year and a half" and that when he got approval to receive them it was discovered that they had "gone missing". (There is no record of when or by whom Mr Port was told that his books had been approved and were now missing.) Mr Port also wrote that he was "stuck" at Hull with "no chance of progression" or of moving to a Category C prison. He wrote that he was "depressed" by the situation and was "giving up hope".

Contact with Mr Port's family

61. At around 11.20am, a prison family liaison officer telephoned Mr Port's parents and told them of his death. (Family liaison officers usually break the news of a death in person but were instructed to do so by telephone during the COVID-19 pandemic.)

62. The family liaison officer told us that he returned some religious books to Mr Port's parents and that these all came from Mr Port's cell. He said that there were no books in Mr Port's stored property to return.

Support for prisoners and staff

63. After Mr Port's death, an operational 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.

64. A custodial manager who knew the cellmate visited him at his place of work and told him of Mr Port's death. The cellmate told us that he received considerable support from staff afterwards.

Post-mortem report

65. Post-mortem and toxicology examinations identified the cause of death as sertraline and paramethoxy-amphetamine (PMA) toxicity. PMA is a stimulant drug, with psychedelic effects similar to MDMA (Ecstasy).

Findings

Identifying the risk of suicide and self-harm

66. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at HMP Hull should have recognised Mr Port as at risk and started ACCT procedures.

67. Mr Port had some risk factors for suicide and self-harm. He had attempted suicide in the community and had previously been admitted to a psychiatric hospital under the Mental Health Act after disclosing suicidal intent. It was Mr Port's first time in prison, and staff and his cellmate told us that he had struggled to settle in his early weeks at Hull. He was appropriately managed under ACCT procedures at one stage as a result.

68. As time went on, Mr Port appeared to have become more accustomed to prison life. He began working in a job as a trusted prisoner, which he told others that he enjoyed. Staff and his cellmate told us that he appeared settled in prison. Most of those with whom we spoke thought that Mr Port had no issues or problems in prison, although some said that he seemed to be a naturally anxious person, and some identified that he was concerned about the books he had ordered. The content of his suicide note indicated that Mr Port was also anxious about the time he had left to serve. (At the time of his death, Mr Port had served over half of the custodial portion of his sentence and was due for release in June 2022.)

69. We are satisfied that staff engaged regularly with Mr Port. Although key working sessions with a dedicated prison officer were suspended across the prison estate during the pandemic, Mr Port was seen regularly for welfare checks and staff made reasonably detailed records of their conversations (in contrast to some prisons where the same 'cut and paste' entries are made for every prisoner and for every check). In addition, Mr Port was regularly seen by members of the chaplaincy team. He also had virtual visits with a friend and, unlike many prisoners during the pandemic, he spent a lot of time outside his cell because of his job.

70. No one who met Mr Port in the weeks before his death considered that he was at increased risk, and staff and prisoners alike described his death as unexpected. We are satisfied that it was reasonable for staff to have concluded that Mr Port did not pose a risk of suicide or self-harm, which warranted ACCT monitoring, in the weeks leading to his death. We do not consider that staff could reasonably have predicted his actions.

Clinical care

Mental health care

71. Mr Port had some contact with the mental health team at Hull, usually after he expressed symptoms of anxiety or stress. He was assessed each time and discharged when clinicians found that he did not have any significant mental health issues or ongoing care needs. Mr Port was referred to mental health support groups and was given self-help material, at his request.

72. The clinical reviewer found that Mr Port received appropriate care for his mental health in prison, equivalent to that which he could have expected to receive in the community.

Diabetes management

73. The clinical reviewer identified that Mr Port's diabetes care plan was reviewed in line with national guidelines and that he was reviewed appropriately by the diabetic specialist nurse. She found that his blood glucose levels were reviewed and recorded appropriately.

Emergency response

74. The clinical reviewer identified quick and timely responses by prison officers and a nurse when Mr Port was found unresponsive on the morning of 11 May 2021. She found that the nurse's actions were appropriate in response to her clinical findings.

Substance misuse

75. Mr Port took his life by taking an overdose of sertraline, which he was prescribed, and paramethoxy-amphetamine (PMA), an illicit drug.

76. Mr Port kept sertraline in his cell to take as prescribed. This is standard practice for prisoners who have passed an 'in-possession' medication assessment, which considers factors such as the risk of suicide and self-harm and any evidence that the prisoner might not understand when or how to take their medication. Mr Port's in-cell medication was removed for several weeks, around nine months before he died, when ACCT procedures were started. However, in the weeks leading to his death, there was no indication that Mr Port was at risk of suicide or self-harm or deliberate (or accidental) overdose. We are therefore satisfied that it was reasonable for Mr Port to have been allowed to keep medication, including sertraline, in-possession in his cell.

77. We do not know where, when or how Mr Port obtained PMA. He had no recorded history of substance misuse in prison and his cellmate told us that he understood that Mr Port did not use drugs in prison. We have seen no evidence to link Mr Port to the prison drugs trade in any capacity.

78. From August 2018, Hull was part of the 'Ten Prisons project' (a programme of activities to improve safety, security and decency at identified prisons, including

preventing drugs entering the prison). In their inspection of July 2021, HMIP reported that Hull had used additional funding through the project to strengthen defences against drugs coming into the prison. They found evidence that drug use had lessened at Hull, including a significant fall in the number of prisoners who said that it was easy to obtain illicit drugs.

79. It is apparent that Hull has made significant progress in their efforts to reduce the supply and use of illicit drugs at the prison and we do not therefore make a recommendation. However, Mr Port's death is a reminder to prison managers that illicit drugs are still available and obtainable even by those prisoners who might be considered as unlikely drug users.

Withheld property

80. The note that Mr Port left in his cell indicated that he was upset that what he described as religious books had been withheld and that he was later told that they were missing. It is not clear whether he was referring to books he had brought into prison with him or to books he had ordered while in prison.

81. Reception staff recorded "inappropriate" books on Mr Port's property card on 9 April 2021. There is no record in his security intelligence record or elsewhere about this or to indicate why the books were inappropriate.

82. PSI 12/2011 on prisoners' property states that prisoners must be told the reasons for the confiscation of their property and that this must be recorded. Reception staff said that they remembered "communicating" with Mr Port about his withheld books, although there is no record of this.

83. In the absence of any evidence or records we cannot say if it was reasonable for the books to have been withheld from Mr Port or whether this was ever explained to him. There is also no record that Mr Port's books were missing or that anyone told him about this. We do not know what happened to Mr Port's books but note that there were no books in his stored property returned to his family.

84. Prisoners' possessions can be a very important source of identity for them, and property associated with their religion may be particularly important to them. It is therefore essential that prisons keep full and accurate records of prisoners' property. This clearly did not happen in this case. We make the following recommendation:

The Governor should ensure that temporarily confiscated property is properly recorded and stored and that prisoners are informed of the reasons for the confiscation in line with national instructions.

Inquest

85. The inquest into Mr Port's death was held on 23 May 2023. The conclusion was that Mr Port died of sertraline and PMA toxicity.

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