Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Samuel Jones, a prisoner at HMYOI Portland, on 1 May 2021

A report by the Prisons and Probation Ombudsman

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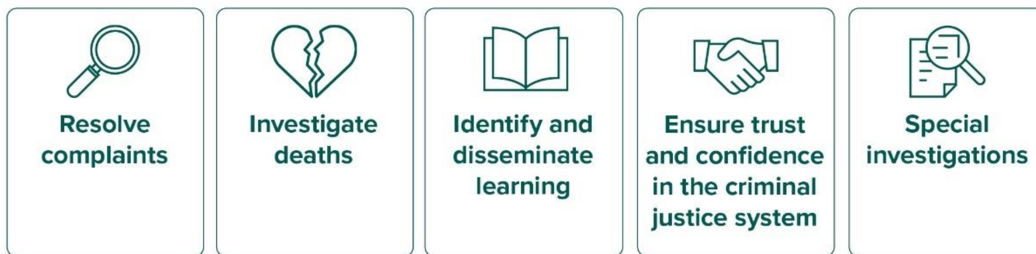
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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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 Samuel Jones was found hanged in his cell at HMP Portland on 1 May 2021. He was 22 years old. I offer my condolences to his family and friends.

Mr Jones arrived at Portland on 8 September 2020, following his recall to prison. He had a history of mental health issues and had been supported using Prison Service suicide and self-harm procedures (known as ACCT) on two occasions in 2019, prior to his release on licence.

I am concerned that opportunities were missed to start ACCT procedures in the weeks before Mr Jones's death, when his behaviour declined, and he said he was struggling because the anniversary of his mother's death was approaching.

The clinical reviewers had numerous concerns about the quality of Mr Jones's mental health care at Portland. In particular, the nurse who discharged Mr Jones from the mental health team in January did not do a proper review and failed to note that Mr Jones had stopped taking his antidepressant medication.

The clinical reviewers also noted that there were very limited mental health services available at Portland. This was partly due to the COVID-19 pandemic but also due to significant gaps in staffing and service. This is an issue we have raised with Portland, and with the NHS Commissioner, before.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **October 2022**

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Summary

Events

1. Mr Samuel Jones was recalled to prison on 13 August 2020. He was moved to HMP Portland on 8 September.

2. Mr Jones had a long history of mental health issues and substance misuse. He had been supported using Prison Service suicide and self-harm prevention procedures (known as ACCT) on two occasions while in prison in 2019. Mr Jones also had dyslexia and problems with reading and writing.

3. In January 2021, Mr Jones stopped taking his antidepressant medication and his behaviour declined. He started misusing his cell bell and being abusive to staff. On 20 February, the electricity in his cell stopped working. He produced a noose and said he could not cope without a television. Staff moved him to another cell.

4. Staff noted that Mr Jones's mood was very up and down, and his behaviour was erratic. He told staff he was struggling as it was coming up to the anniversary of his mother's death (she took her own life in April 2014).

5. At around 5.55am on 1 May, during a routine roll check, an officer found Mr Jones hanging from the bed. Staff did not try to resuscitate him as it was clear he was dead. Ambulance paramedics confirmed Mr Jones's death at 6.20am.

Findings

6. We are concerned that staff failed to consider starting ACCT procedures when Mr Jones produced a noose and when he subsequently said he was struggling as the anniversary of his mother's death was approaching. There was also poor communication between prison and healthcare staff about the decline in Mr Jones's behaviour.

7. The clinical reviewers had numerous concerns with the quality of Mr Jones's mental health care. There was a lack of care planning for Mr Jones's depression, he was discharged from the mental health team in January 2021 without a proper review and with no reference to the fact that Mr Jones had stopped taking his antidepressant medication. Mr Jones's antidepressant medication was stopped in February by a pharmacy technician, and it is unclear whether the mental health team was informed. Also, Mr Jones's problems with reading and writing were not recorded properly which meant he did not always get the support he needed.

8. The clinical reviewers found that during the time Mr Jones was at Portland, there were limited mental health services available. This was partly due to the COVID-19 pandemic but also due to significant gaps in staffing and service. We have previously raised concerns about the provision of mental health care at Portland.

Recommendations

- The Governor and Head of Healthcare should ensure that staff:
    - consider all information when assessing a prisoner’s risk of suicide and self-harm;
    - start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner’s stated intentions;
    - record the information considered and their reasoning when they decide not to start ACCT procedures; and
    - are reminded of the importance of sharing information that would inform assessment about a prisoner’s risk of suicide and self-harm so that all relevant factors are considered when deciding whether to start ACCT procedures.

- The Head of Healthcare, along with the mental health lead and the lead GP, should review any guidance on the diagnosis and treatment of depression and anxiety at Portland to ensure that it meets NICE standards, to include advice on care planning and use of structured review tools.
- The Head of Healthcare should ensure that prior to discharging a patient from mental health services, there is a multidisciplinary team review which seeks input from all those involved in the person’s care, including drug and alcohol services.
- The Head of Healthcare, along with the mental health lead and lead GP, should review whether pharmacy technicians should be able to stop antidepressant medication and if so, the process that should be followed.
- The Head of Healthcare should ensure that learning difficulties are clearly identified and recorded in the prisoner’s medical record, including what support and adjustments are necessary, and that they are considered when completing assessments and treatment plans.
- The Head of Healthcare should audit the current provision of mental health services at Portland and identify any gaps in service that affect the review, care, and treatment of patients.

The Investigation Process

9. 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. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Jones's prison and medical records.

11. We suspended our investigation between August 2021 and April 2022 due to delays in appointing the clinical reviewers.

12. NHS England commissioned a clinical reviewer to review Mr Jones's clinical care at the prison.

13. The investigator interviewed 13 members of staff and one prisoner at Portland during August 2021. She also contacted a member of staff from the Post-Release Casework Team. Further interviews were conducted with the clinical reviewers between January and March 2022.

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

15. The Ombudsman's family liaison officer contacted Mr Jones's father to explain the investigation and ask if the family had any issues they wanted the investigation to consider. The family had no questions.

16. Mr Jones's family received a copy of the initial report. They did not identify any factual inaccuracies.

17. The prison also received a copy of the report. We have amended the time of healthcare cover, corrected the spelling of a surname and the grade of a member of staff.

Background Information

HMYOI Portland

18. HMYOI Portland holds up to 530 adult and young adult male prisoners. Mental and physical healthcare is provided by Practice Plus Group. Substance misuse services are provided by EDP (Exeter Drugs Project) Drug and Alcohol Services. Primary healthcare is provided every day between 7.30am and 6.00pm and mental healthcare is provided Monday to Friday from 8.00am to 5.00pm.

HM Inspectorate of Prisons

19. The most recent full inspection of HMYOI 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.

20. Inspectors found that the mental health service did not meet the service specification and was not informed by an up-to-date 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.

Independent Monitoring Board

21. 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.

22. Problems with the appointment and retention of mental health and psychology staff and delays in diagnosis and treatments had 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.

Previous deaths at HMYOI Portland

23. Mr Jones was the second prisoner to die at Portland since May 2019. The other death was also self-inflicted, by a prisoner who had been recalled to custody. We made a recommendation about the mental health provision at Portland.

Assessment, Care in Custody and Teamwork

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 support the prisoner. 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)*.

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 (a 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.

Licence recall

26. 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.

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

Key Events

28. In June 2019, Mr Samuel Jones was sentenced to 28 months imprisonment for violent offences. He was released on licence from HMP Portland on 17 April 2020, but was recalled to prison on 13 August, for breaching his licence. (It was a standard recall and Mr Jones's sentence expiry date (SED) was 17 June 2021.) He was moved back to Portland on 8 September.

29. Mr Jones had a history of mental health issues and self-harm. His mother had taken her own life in April 2014 which had severely impacted his own mental health.

30. In 2019, Mr Jones was supported using Prison Service suicide and self-harm prevention measures (known as ACCT) on two occasions. He had a history of substance misuse including alcohol, cannabis, ecstasy, and cocaine. He also had problems with reading and writing.

31. Nurse A completed Mr Jones's initial health screen on 9 September, the day after he arrived at Portland. He referred Mr Jones for a full mental health assessment and to the substance misuse team. He did not note Mr Jones's dyslexia or reading and writing difficulties.

32. On 15 September, staff discussed Mr Jones at a mental health team meeting and noted that he was going to work with the chaplain on bereavement. The next day, Mr Jones failed to attend an appointment with Nurse A, his allocated mental health caseworker. The nurse saw him on the wing, and they agreed to meet the next day. However, there is no evidence in the medical record that they met again until 21 September, when the nurse carried out a mental health assessment and review. He recorded that Mr Jones 'appeared bright' and had no thoughts of suicide or self-harm. There was no record of a care plan.

33. The same day, another nurse also met with Mr Jones and they completed a detailed substance misuse assessment. Mr Jones agreed to engage with substance misuse services.

34. On 26 October, a drug recovery worker met with Mr Jones for the first time. Mr Jones told her he was only going to be in prison for a few months and they discussed his needs, agreed to complete motivational work around his substance misuse and completed a recovery plan. They met again on 16 November, when Mr Jones said he was feeling anxious about his release, but they spoke about planning to mitigate these anxieties (registering with a GP, applying for Universal Credit, and discussing employment options with his probation officer).

35. On 1 December, Mr Jones submitted an application to speak to someone from the mental health team as he felt that he was struggling with his mental health. A task was sent to Nurse A, but he no longer worked at Portland so there was no response. On 7 December, Mr Jones asked a member of healthcare staff when he would see the mental health team and they sent a task message to Nurse B in the mental health team. The next day, during his meeting with his drug recovery worker, Mr Jones told her that he was beginning to struggle with depression and anxiety and was feeling low. Mr Jones said he did not have any thoughts of suicide or self-harm. She told him that she would contact the mental health team.

36. On 9 December, Nurse B tried to meet with Mr Jones, but was unable to as he was on the exercise yard and then there was no available room on the wing for them to meet. They met on 11 December. Mr Jones said he was feeling low, anxious, and no longer enjoyed the things he used to. He said that his drug use may have affected his mental health. The nurse noted that Mr Jones would benefit from psychological support and medication. He referred Mr Jones for discussion at the next mental health team meeting and to the psychologist. (There was no provision for psychology services at this time due to staff shortages.) There is no evidence a care plan was completed.

37. On 15 December, Nurse B discussed Mr Jones with a senior mental health nurse (he recorded it as a multidisciplinary meeting even though it was not). They agreed to prescribe Mr Jones with an antidepressant (sertraline). The next day, Nurse B met with Mr Jones who agreed to start the antidepressant medication. They agreed to review how things were in four weeks.

2021

38. On 10 January 2021, Nurse B met with Mr Jones for a review of his mental health. Mr Jones said that the medication was helping and that he felt less anxious, but his mood still fluctuated. He noted that Mr Jones said he had no thoughts of suicide or self-harm and was still on the waiting list for psychology.

39. On 11 January, Mr Jones started work in the laundry. Staff had noted that he had shown a mature attitude and was complying with the wing regime. However, on 20 January he was abusive and made threats to an officer. Staff placed him on report (a disciplinary charge) and moved him to the Care and Separation Unit (CSU – the segregation unit). He returned to Benbow Unit the next day and later apologised to the officer. Over the next week, Mr Jones's behaviour continued to be challenging at times; he misused his emergency cell bell and was abusive to staff when they would not leave his door open when the unit was being cleaned.

40. On 25, 27 and 29 January, the drug recovery worker tried to contact Mr Jones on his in-cell telephone, but he did not answer.

41. On 28 January, Nurse B met with Mr Jones to review his mental health. He noted that Mr Jones was stable and had no thoughts of suicide or self-harm. He discharged Mr Jones from his caseload but told him that he could refer himself to the mental health team at any time if he was in crisis. There is no record that he explored the reasons why Mr Jones had been placed in the CSU, how the antidepressant medication was affecting his mood, whether he was taking it every day or having side effects. (Mr Jones had in fact not been collecting his medication but this had not been checked.)

42. On 2 February, the drug recovery worker met Mr Jones on his wing. They reviewed his plan and Mr Jones said he was doing well and looking forward to his release. Mr Jones spoke about his anxieties around release, and they agreed to focus on release planning over the next few weeks. Later, a pharmacy technician messaged the mental health team to tell them that Mr Jones had not collected his medication since the middle of January. The next day, a mental health lead noted that Nurse B was going to see Mr Jones about his medication compliance and whether it was

necessary to reinstate him on his caseload, but there is no evidence he went to see Mr Jones.

43. On 9 February, Mr Jones told an officer during a key worker session that he was getting used to being in a cell on his own (after his cellmate had been released) and wanted to get a job. Later the same day, another officer met with Mr Jones for a routine welfare check. She recorded that she had had a long chat with Mr Jones who said he had been told the previous day that he did not get parole but was staying positive as he only had a few months to serve before he was released.

44. On 11 February, an officer met with Mr Jones for a key work session. He said he was a bit lonely without a cellmate but when asked who he would like to share with, did not name anyone. The officer recorded that Mr Jones said he was okay and wanted to 'keep his head down' before he was released.

45. On 12 February, a pharmacy technician noted that Mr Jones had stopped collecting his antidepressant medication because he wanted to try and deal with his problems on his own. She stopped his medication and noted that she planned to send a task to the mental health team to alert them. It is unclear whether this message was ever sent.

46. On 15 February, an officer warned Mr Jones about misusing his emergency cell bell and swearing at staff. Later, an officer spoke to Mr Jones and noted he seemed down. She asked him again about sharing a cell, but he told her he was not sure if he wanted to and told her he was happy on his own.

47. On 20 February, a Healthcare Assistant (HCA) recorded in Mr Jones's medical record that she had assessed him after he hit his head. She noted that Mr Jones said he had been cleaning his room and stood up and banged his head on the cupboard door. She recorded that Mr Jones had a small cut approximately 1cm long in the middle of his head, on his hairline, but that he had no headache and did not feel dizzy.

48. That night, an operational support grade (OSG) recorded in the wing observation book that Mr Jones had pressed his cell bell as he had no electricity in his cell. When she told him that there was nothing that could be done until the morning, Mr Jones produced a 'noose', said he had mental health issues and could not cope without a television. She recorded that she told the night manager and staff moved Mr Jones to a different cell and reported the electricity issue.

49. On 22 February, an officer recorded in Mr Jones's prison record that she had been asked by Safer Custody to investigate the incident when Mr Jones had headbutted the wall (on 20 February). Another officer noted that there were no visible injuries. She recorded that Mr Jones said that he had not intended to self-harm and he had done it because he was angry about the loss of power in his cell.

50. Later the same day, an officer made two entries in Mr Jones's prison record. At 7.30pm, she noted that Mr Jones had been confrontational, threatened staff and threatened to jump onto the security netting. At 8.24pm, she completed a welfare check. She noted that Mr Jones's mood was very up and down and that he was struggling, which was affecting his behaviour on the wing.

51. On 28 February, an officer completed a welfare check. She noted in Mr Jones's prison record that he seemed to be struggling, that he found it hard being in a cell on his own and that he found it difficult as it was around the time of the anniversary of his mother's death. Mr Jones said he had no thoughts of suicide or self-harm. She discussed a move to another wing as a progressive move for Mr Jones. There is no further record of a wing move or that the mental health team was contacted.

52. On 2 March, the drug recovery worker met with Mr Jones. Mr Jones told her that he was still waiting on a decision from the Parole Board and was hopeful that he would be released when there was a space in a hostel. Mr Jones said that he felt he could stay drug free when released and wanted to engage with the community mental health team. She noted that Mr Jones was able to identify protective factors, coping strategies and did not need any additional support.

53. On 8 March, a member of the Catch 22 resettlement team sent Mr Jones information to start his 12-week resettlement plan, for his release.

54. Over the next couple of weeks, an officer met with Mr Jones several times for welfare checks. Mr Jones told him that he was still struggling on the wing and that he would like to work in the kitchen. He recorded that Mr Jones's work risk assessment was reviewed, but as he remained a medium risk, he was not able to be employed in the kitchen. He arranged for Mr Jones to start working in the laundry.

55. On 18 March Mr Jones received a negative warning for refusing to attend work. He told staff he preferred to attend the gym which clashed with working in the laundry. The same day, Mr Jones approached the drug recovery worker when she was on his wing. He told her that his parole date was 7 April, and he was hopeful he would be released. Mr Jones said he was feeling more confident and that he was optimistic that he could avoid using substances when released. She agreed to meet with Mr Jones to discuss coping strategies.

56. On 23 March, Nurse B made an entry in Mr Jones's medical record to say that he could not meet with him due to other commitments but would rebook an appointment for 26 March. (There is no record a meeting took place or was attempted on 26 March.) On 29 March, Nurse B met with Mr Jones to review his mental health. Mr Jones said he had been well, had been drug free for some time, but would like therapy or counselling when released to discuss his problems. The nurse noted that Mr Jones was still on the waiting list for psychology.

57. On 30 March, an assistant psychologist met with Mr Jones. She recorded that she had received a call from the wing and that he was struggling with his mental health. Mr Jones told her that he wanted someone to talk to and did not feel himself. Mr Jones disclosed his previous drug use and that his mother's death had affected his mental health. She told Mr Jones that she would see him in a few weeks and bring him a referral letter for therapy in the community when he was released. There was no evidence of a plan to support Mr Jones in the interim before his release.

58. On 31 March, another Catch 22 member met with Mr Jones and completed a full assessment of his resettlement needs. The next day, Mr Jones asked an offender supervisor about his parole hearing. She told Mr Jones that reports were due to be

submitted in the middle of April and that a decision should be made by the Parole Board ‘shortly’.

59. On 6 April, an officer recorded that he had given Mr Jones a negative report for hiding from staff then becoming abusive. On 9 April, the officer met with Mr Jones for a welfare check. Mr Jones apologised for his behaviour a few days earlier and asked if they could ‘put the matter behind them’, which the officer accepted.

60. On 12 April, the drug recovery worker met with Mr Jones. He told her that he continued to grow in confidence and was doing well. They discussed his parole decision and Mr Jones explained that he was anxious about housing and his finances. She spoke to a member of Catch 22 and she arranged to meet Mr Jones the next day. The drug recovery worker told Mr Jones that when he had received his parole decision, they would meet to complete his release workbook.

61. On 13 April, a member of Catch 22 met with Mr Jones, as she had been asked to complete a housing assessment by his probation officer, because he was being considered for early release. She noted that she had contacted Mr Jones’s housing officer, who told her that Mr Jones was not deemed a priority need, but that he did qualify for help with supported accommodation and would apply to every possible supported housing and update her.

62. On 23 April, there is an entry in Mr Jones’s medical record by the assistant psychologist to say that she has sent a letter to him to ask if he wanted to be added to a talking therapies group for those with low mood and anxiety. There is no evidence anyone considered his learning difficulties and read the letter to him and Mr Jones did not respond.

63. On 24 April, a Supervising Officer (SO) recorded that during a welfare check, she discussed issues Mr Jones had had with staff and he made threats to get on the security netting and was rude and abusive. On 27 April at 9.32am, an officer recorded a negative entry in Mr Jones’s prison record as he had stayed in bed and refused to get up when unlocked.

64. On 29 April, Mr Jones pressed his emergency cell bell six times between 9.47am and 5.56pm. On every occasion it was answered by a member of staff in less than one minute. There is no record of why Mr Jones had used his emergency cell bell in either his prison record or wing observation book. During the day, an officer asked Mr Jones to find someone to share a cell with, as the prison needed space. Mr Jones refused and said he was not willing to share with anyone.

65. While on exercise, Mr Jones approached the regional mental health lead and asked her if he could speak to someone from the mental health team about his medication. She told him she would make the request on his behalf. A mental health worker went to see Mr Jones and told him that he would be seen the next day and reviewed by a mental health nurse. Neither of these contacts with Mr Jones were recorded in his medical record.

66. On the morning of 30 April, a nurse went to the wing to assess Mr Jones’s mental health. She recorded that Mr Jones was anxious, struggled to put a sentence together and was having trouble sleeping. Mr Jones said he had stopped taking his antidepressant medication some months before as he wanted to deal with things on

his own but realised this was a mistake. She said she would prescribe his antidepressant medication and a course of Nytol, to help reset his sleep pattern (Mr Jones did not collect the Nytol medication).

67. CCTV shows that an officer carried out a roll check at 5.46pm. At 7.04pm, an officer recorded that he had completed a welfare check during the day. He noted that Mr Jones said he had no issues, but that he was going to refuse to be locked up. He recorded that despite this, Mr Jones was locked up without any issues. At 8.22pm, another roll check was completed.

68. Mr Jones maintained contact with his family and friends throughout his time at Portland. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to the calls made by Mr Jones in the days before he died. Mr Jones spoke to his father, the Probation Service, and a friend, but there was nothing in these calls that suggested Mr Jones was in crisis or considering suicide.

1 May

69. CCTV shows that the night patrol officer carried out the early morning roll check and arrived at Mr Jones's cell at 5.55am. She opened the observation panel, used the night light, and saw Mr Jones hanging by a piece of clothing (jogging bottoms) attached to the end of his bed. She used her radio to ask for assistance and then confirmed it was a code blue medical emergency. Less than a minute later several staff responded to the emergency request and an officer unlocked the door. The control room called for an ambulance at 5.56am.

70. Staff entered the cell, and as they held and lowered Mr Jones to the floor the ligature fell to the floor. They described Mr Jones as cold, stiff and did not start cardiopulmonary resuscitation (CPR) as it was clear that he was dead. A Custodial Manager (CM) also responded to the code blue.

71. Paramedics arrived at Mr Jones's cell at 6.17am and at 6.20am confirmed his death. Paramedics noted there were clear signs that Mr Jones had been dead for some time.

After Mr Jones's death

72. On 4 May, a security intelligence report was submitted which stated a friend of Mr Jones told staff that he was in debt to other prisoners on Benbow Wing and they had threatened to send people to the prison on the day of his release. There was no other information available to the investigator which corroborated this information.

Contact with Mr Jones's family

73. Portland appointed a family liaison officer (FLO) and a deputy. They travelled with a prison manager to Mr Jones's father to break the news of his death. They offered their condolences and ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Mr Jones's funeral, which was held on 1 June.

Support for prisoners and staff

74. After Mr Jones's death, the Deputy Governor and a prison 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 attended and offered support. The prison posted notices informing other prisoners of Mr Jones'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 Jones's death.

Post-mortem report

75. The post-mortem report concluded that Mr Jones's death was due to hanging (ligature suspension). Toxicology tests showed the presence of sertraline, which was re-prescribed to Mr Jones on 30 April, but which had not been dispensed at the time of his death.

Findings

Management of Mr Jones's risk of suicide and self-harm

76. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody*) sets out the procedures (known as ACCT) that staff must follow when they identify that a prisoner is at risk of suicide and self-harm. Mr Jones was managed using ACCT on two occasions in 2019 but at no time were ACCT procedures used following Mr Jones's recall to custody on 13 August 2020.

77. During the night of 20 February 2021, Mr Jones produced a ligature when his electricity failed, yet no one considered starting ACCT procedures. There was nothing recorded in his prison record and the mental health team was not informed. In the weeks before he died, Mr Jones's behaviour became more erratic. He was misusing his emergency cell bell and had asked on several occasions for help to manage his emotional distress connected to his grief and upcoming release. In the days before he died Mr Jones told prison and healthcare staff that he was 'struggling', yet there is no evidence of any meaningful communication between prison and healthcare staff, or that these anxieties were fully explored. All these factors should have resulted in a more coordinated, considered, approach to supporting Mr Jones.

78. The Head of Safety and Equalities told the investigator that all night staff had been refreshed in the ACCT process. In addition, recalled prisoners, and those due for parole, were now seen daily for a welfare check, six weeks before release, to identify any risks or concerns. They were also discussed as a separate risk group at the weekly Safety Intervention Meeting (SIM - to discuss managing risks to prisoners and the prison).

79. While we welcome that Portland has already implemented some changes since Mr Jones's death, we consider that more needs to be done to improve how staff identify and assess prisoners at risk of suicide and self-harm. We therefore recommend:

The Governor and Head of Healthcare should ensure that staff:

- **consider all information when assessing a prisoner's risk of suicide and self-harm;**
- **start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions;**
- **record the information considered and their reasoning when they decide not to start ACCT procedures; and**
- **are reminded of the importance of sharing information that would inform assessment about a prisoner's risk of suicide and self-harm so that all relevant factors are considered when deciding whether to start ACCT procedures.**

Clinical care

Mental health

80. The clinical reviewers concluded that there was limited evidence to show that there had ever been a comprehensive approach to understanding the trauma that Mr Jones had experienced to inform the approach to his care. They found that there were no records to suggest that staff used structured review tools such as PHQ-9 or GAD-7 to form an objective view of Mr Jones's psychological state. There was limited evidence of a structured assessment to identify depression. The clinical reviewers were unable to establish definitively if Mr Jones ever received bereavement therapy or any other psychological support. When Mr Jones asked a nurse for an antidepressant the day before he died, the nurse did not properly assess him or arrange a follow up. We recommend:

    The Head of Healthcare, along with the mental health lead and the lead GP, should review any guidance on the diagnosis and treatment of depression and anxiety at Portland to ensure that it meets NICE standards, to include advice on care planning and use of structured review tools.

81. Nurse B discharged Mr Jones from the mental health team on 28 January, even though the planned intervention from the psychology service had not been achieved. He recorded that Mr Jones was 'stable on his medication'. However, there was no record that he asked Mr Jones how the medication was affecting his mood, whether he was taking it every day and whether he had side effects. In fact, Mr Jones was not taking his medication, but this was not checked. The nurse concluded that Mr Jones had no current mental health issues, but there was no evidence that he explored the reasons behind Mr Jones's recent period in segregation. We recommend:

    The Head of Healthcare should ensure that prior to discharging a patient from mental health services, there is a multidisciplinary team review which seeks input from all those involved in the person's care, including drug and alcohol services.

82. On 12 February, a pharmacy technician stopped Mr Jones's antidepressant medication as he had stopped collecting it and said he wanted to try to deal with his problems on his own. She noted that she planned to send a task to the mental health team, but it is unclear whether this message was ever sent. We recommend:

    The Head of Healthcare, along with the mental health lead and lead GP, should review whether pharmacy technicians should be able to stop antidepressant medication and if so, the process that should be followed.

83. The clinical reviewers found that not all staff were aware of Mr Jones's problems with reading and writing. This was not flagged at his initial healthcare screening when he arrived back at Portland in September 2021. Consequently, when he was provided with a workbook by his mental health nurse, no additional support was provided to help him complete it. We recommend:

The Head of Healthcare should ensure that learning difficulties are clearly identified and recorded in the prisoner's medical record, including what support and adjustments are necessary, and that they are considered when completing assessments and treatment plans.

84. The clinical reviewers found that during the time Mr Jones was at Portland, between September 2020 and May 2021, there were very limited mental health services available. This was partly due to COVID-19 service pressures but more due to the significant gaps in staffing and service. There was little or no provision of talking therapy or psychological therapy during this time. Mr Jones saw a GP on only one occasion and no doctor from the mental health team. The multidisciplinary discussions were very limited and on at least one occasion, was limited to an operational discussion between two nurses.

85. In a previous investigation into the death of a prisoner at Portland in December 2019, we identified severe problems with the provision and oversight of the prison's mental health service. In April 2021, we recommended that the NHS Commissioner should urgently review the mental health service at Portland with the Governor and Head of Healthcare and ensure the service specification was being met and an effective service was being delivered to all prisoners. In response, we were told that the Regional Mental Health Lead was reviewing compliance with the mental health specification and developing learning tools and audits to support further work. We recommend:

The Head of Healthcare should audit the current provision of mental health services at Portland and identify any gaps in service that affect the review, care and treatment of patients.

Substance misuse

86. Mr Jones was well supported by his drug recovery worker. There is evidence she considered his learning difficulties and adjusted her contact accordingly. Mr Jones received advice and learned techniques to avoid relapsing when he left prison.

Parole Board review

87. There were delays in getting Mr Jones's recall decision considered by the Parole Board. On 8 October 2020, the Parole Board adjourned Mr Jones's case and requested further information by 19 November. However, this was missed by the caseworker in Public Protection Casework Section (PPCS) and was not picked up until a management check was carried out on 16 February 2021.

88. The Parole Board adjourned the case again on 8 March and asked for an updated report by 20 April. The report was sent by email to a generic recall inbox and to the PPCS caseworker on 21 April. However, the caseworker missed this and said that he must have deleted it in error (Mr Jones had not been recommended for release). On 27 April and 7 May, the Parole Board requested an update directly from the caseworker about the outstanding report, but he did not respond.

89. A PPCS manager investigated the handling of this case and concluded that it was an oversight on the caseworker's part, due to an increased caseload while the team was carrying vacancies. She said that no process changes were needed as there

were checks already in place to identify outstanding targets, which is how the error was first identified in February. However, the caseworker was given advice and guidance about managing their caseload. We make no recommendation.

Inquest

90. The inquest into Mr Jones' death concluded in November 2023. Mr Jones' death was recorded as ligature suspension. A narrative verdict was given as there was insufficient evidence presented to the jury as to whether Mr Jones intended to take his own life.

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