C.G.BUTLER
SENIOR CORONER · BUCKINGHAMSHIRE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Governor, HMP Woodhill** 2. **The Chief Executive, Central & North West London NHS Foundation Trust**
1	**CORONER** I am CRISPIN GILES BUTLER, Senior Coroner for BUCKINGHAMSHIRE
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/pdfs/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 31st December 2015 Senior Coroner Richard Alexander Hulett commenced an investigation into the death of JACK OLIVER PORTLAND, aged 29 years. The investigation concluded at the end of the inquest on 3rd February 2017. The conclusion of the inquest was set out in the Jury's narrative conclusion contained in their answers to a questionnaire.
4	**CIRCUMSTANCES OF THE DEATH** Mr Portland was a prisoner at HMP Woodhill until release at the end of a sentence on 16th October 2015. Whilst at HMP Woodhill he was diagnosed with substance-induced psychosis. Two separate ACCT documents were opened during his last period of detention at HMP Woodhill. Following release he could not be assessed at Stoke Mandeville Hospital as he was under the influence of substances and he was subsequently detained at HMP Lewes from 18th October 2015. Upon release from HMP Lewes on 4th November 2015, Mr Portland was sectioned under Section 2 of the Mental Health Act and detained at the Dene Hospital. On 4th December he was detained under Section 3 of the Mental Health Act and was transferred to the Whiteleaf Centre, Aylesbury, Buckinghamshire on 5th December 2015 where he remained a patient until his death on 27th December 2015, which occurred at Wycombe Hospital, High Wycombe whilst Mr Portland was on unescorted S17 leave from the Whiteleaf Centre. Mr Portland had been found and was attended to by paramedics at a house

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	in High Wycombe. The medical cause of death was morphine and ethanol toxicity.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) It was identified that some elements of the management of the ACCT documents during Mr Portland's detention at HMP Woodhill, in particular insufficient detail of prisoner issues in the caremap and in post-closure review, late completion of a post-closure review, communication between healthcare staff (who have access to the healthcare SystmOne records) and prison staff (who do not) were of concern and remain so, notwithstanding general evidence indicating that the prison have been implementing ACCT quality review measures, automatic referral for a mental health assessment on opening of an ACCT and a NOMS-led taskforce. (2) The standard letter notifying a family of the opening of an ACCT was non-specific and dependent upon prisoner consent, yet it was identified that the engagement of families in the ACCT process was important, particularly in the context of risk assessment. It appeared that the same letter is still in use, directing families to telephone extensions for prison staff and healthcare or a 24-hour help line. The family evidence was that communication with the prison in response to a letter received during the first ACCT was of significant concern and that they were not notified of the second ACCT. There was evidence suggesting that the helpline is now attended regularly and messages dealt with but the overall communication paths appear to remain the same. (3) There were concerns about the assessment and management of Mr Portland's discharge needs from admission, particularly with regard to post-release accommodation and positive identification of registration with a GP, given that Mr Portland was homeless and that aftercare ultimately would be dependent upon GP engagement. It was accepted that it is mandatory for prisoner discharges to be undertaken in accordance with the relevant Prison Service Instruction and Early Days and Discharge Specification with all that those encompass. There remains a concern regarding the discharge of prisoners presenting with issues such as those of Mr Portland – a risk of self-harm, substance addiction, homelessness, resolving substance-induced psychosis, vulnerability. (4) In relation to the coronial investigation and the inquest itself, there were significant concerns surrounding the co-ordination of disclosure by HMP Woodhill, initially by volume disclosure direct to the coroner, and subsequently in a piecemeal, partial fashion via Government Legal Department. Emails in which prison staff and/or healthcare staff were participants and which were very relevant to issues raised in the inquest became identifiable only through probation records and there was a concern that relevant communications should have formed part of the specific prisoner records and been part of the HMP Woodhill disclosure. Whilst significant urgent work was undertaken by Government Legal Department during the inquest itself to assist the court with additional and correct documentation, these

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	concerns, together with late identification of relevant witnesses and provision of witness statements caused delays to the coronial investigation which may have also have delayed the overall learning process and compromised the ability of HMP Woodhill to implement change in a manner specific to the issues and concerns identified, rather than in the broader terms described during the inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th April 2017. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Messrs Leigh Day, acting for Mr Portland's family. Government Legal Department, acting for the Ministry of Justice, HMP Woodhill Messrs Radcliffes LeBrasseur, acting for Central & North West London NHS Foundation Trust I have also sent it to the Prison & Probation Ombudsman, to HM Inspector of Prisons and to Senior Coroner Osborne, Milton Keynes Coronial Area who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated: 21st February 2017** **Signature:.......................................** **Senior Coroner for Buckinghamshire**

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